DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495362 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 Ashland Nursing and An unannounced Medicare/Medicaid standard Rehabilitation ("Facility") is survey was conducted 10/4/16 through 10/6/16. filing this plan of correction for Complaints were investigated during the survey. Corrections are required for compliance with 42 purposes of regulatory CFR Part 483 Federal Long Term Care compliance. The Facility Is requirements. The Life Safety code survey/report submitting this plan of will follow. correction to comply with the applicable law. The The census in this 190 certified bed facility was submission of the plan of 162 at the time of the survey. The survey sample correction does not represent consisted of 26 current resident reviews an admission or statement of (Residents #1 through #22 and #29 through #32) agreement with respect to the and six closed record reviews (Residents #23 alleged deficiencies. through #28). F 160 483.10(c)(6) CONVEYANCE OF PERSONAL SS=D FUNDS UPON DEATH F 160 RECEIVED Upon the death of a resident with a personal fund deposited with the facility, the facility must convey NOV 0 3 2016 within 30 days the resident's funds, and a final accounting of those funds, to the individual or **VDH/OLC** F160 , 12VAC5-371-160E probate jurisdiction administering the resident's estate. (1) Resident #25's refund has been issued. This REQUIREMENT is not met as evidenced by: (2) All residents have the Based on staff interview, facility document review

and clinical record review, it was determined that the facility staff failed to convey resident funds upon death for one of three closed record reviews, Resident #25.

Resident #25 expired on 8/20/16 and the resident fund has not been dispersed at the time of the survey, a total of 46 days.

potential to be affected by deficient financial practices. The facility will conduct a 100% audit of all resident trust funds to identify other residents who have been discharged or expired since the last annual survey.

LABORATORY DIRECTION'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) OATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days oldersateguards provide survives an including policition to the policition. (Occurrence of the content of the c days bllowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

STATEMENT OF OFFICIENCIES	& MEDICAID SERVICES		PRINTED: 10/18/2( FORM APPROV
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## F 160 Continued From page 1

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The findings include:

Resident #25 was admitted to the facility on 3/25/16 with diagnoses that included but were not limited to: atrial fibrillation, dementia, macular degeneration, diabetes, anemia, gastritis and impulsive disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/1/16, coded the resident as being severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Review of the clinical record revealed a nurse's note dated 8/20/16 at 8:10 a.m. that documented Resident #25 had expired.

On 10/5/16 at 3:22 p.m. a review of Resident #25's fund account was conducted. The "Resident Statement Landscape" documented on 10/3/16, the resident fund still had \$42.52.

An interview was conducted with administrative staff member (ASM) #3, the regional business office manager, on 10/5/16 at 3:22 p.m. When asked what the status of the account was, ASM #3 stated, "It's frozen, there can be no transactions made to it." When asked the procedure for closing a resident fund account upon the resident's death, ASM #3 stated, "We have to close it within 30 days of the death. We have to wait for the funeral bill to see if the monies go there or to the family." ASM #3 was asked when the money is to be sent to either the family or funeral home. ASM #3 stated, "Within

- F 160
- (3) The facility will: (a) review policies/procedures on resident rights as it relates to refunding money after discharge. ED/designee will educate Business office manager on the above policy (c) The Business Office Manager or designee will receive discharge information 5 x weekly for 1 month and will refund any money due within 30 days then weekly x1 month.

OEFICIENCY)

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: UQB111

Facility IO: VA0008

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NAME OF PROVIDER OR SUPPLIER		<del></del>	STORET ADDRESS	10/06/2016
ASHLAND NURSING AND REF	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 905 THOMPSON STREET ASHLAND, VA 23005	
FREE TEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETION TE DATE
but we don't have the why this had not bee	ed if it had been over 30 days expired, OSM #3 stated, "Yes, e funeral bill." When asked in processed, ASM #3 stated, expressions business office.	F 160	,	
Medicaid Resource L the Business Office monies to the appropri	esident Trust Fund" "Upon the death or nt with personal funds on ty that are less than the evel for a Medicaid resident, nust deliver all remaining riate person by processing a b) days (Federal Regulation			
The administrator and director of nursing ser the above concern on	VICES Were made outper			
No further information F167 483.10(g)(1) RIGHT To SS=D READILY ACCESSIBL	was obtained prior to exit. O SURVEY RESULTS - .E	F 167	F 167, 12VAC5-371-110A (1) Postings regarding the location or availability of the	
A resident has the righ the most recent survey Federal or Slate survey correction in effect with	ht to examine the results of ey of the facility conducted by eyors and any plan of threspect to the facility.		most recent survey results have been placed through the facility.	
The facility must make				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/20-FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-035 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILOING COMPLETED 495362 B. WING NAME OF PROVIDER OR SUPPLIER 10/06/2016 STREET AODRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD (EACH DEFICIENCY MUST BE PRECEDED BY FULL

F 167 \* Continued From page 3

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Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to post the location and availability of the current survey results.

REGULATORY OR LSC IDENTIFYING INFORMATION)

Observations during the survey failed to reveal any postings regarding the location or availability of the most recent survey results.

The findings include:

On 10/4/16 at 2:00 p.m. and 10/5/16 at 10:00 a.m., observation of the facility's 2015 survey results was conducted. The results were located in a three ring binder on a table in the front lobby of the facility. The front of the binder was labeled, "(name of Facility) Survey Results." No further notices of the location of the survey results were posted anywhere else in the lobby.

On 10/5/16 at 11:00 a.m., a group meeting was conducted with four residents. When asked if they knew where the survey results were located, all four residents stated, "No."

Observations of Units Wing # 1, Wing # 2 and : Wing # 3 on 10/5/16 at approximately 3:00 p.m. failed to evidence a notice regarding the location of survey results.

On 10/6/16 at 8:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the administrator. ASM # 1 stated the survey results were located in a binder on a table in the facility lobby. When asked if there was information elsewhere in the facility indicating F 167

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PREFIX

TAG

(2) No residents were affected by this deficient practice.

PROVIOER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCEO TO THE APPROPRIATE

DEFICIENCY)

(X3)

DATE

- (3) ED/designee will educate residents and staff concerning the location of survey results.
- (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

FORM CMS-2567(O2-99) Previous Versions Obsoleta

Event ID: UQB111

Facility ID: VA0008

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUFPLIER/CLIA FORM APPRO AND PLAN OF CORRECTION OMB NO. 0938-(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING\_ (X3) DATE SURVE COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 10/06/201 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ASHLAND, VA 23005 REGULATORY OR LSC IDENTIFYING INFORMATION) ΙD PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG [X5) DEFICIENCY) DATE F 167 Continued From page 4 the tocation of the survey results ASM # 1 stated, F 167 "No. There should be a sign on each unit." The facility's policy "Virginia Resident's Rights and Responsibilities" documented, "Examination of your Records and Survey Results: B. To examine the results of the most recent survey of F 226, the facility conducted by Federal or state (1) C.N.A. #20 has signed and surveyors and any plan of correction in effect with dated the sworn statement. respect to the facility." (2) Residents that reside in the facility have the potential to be On 10/6/16 at 11:20 a.m., ASM #1, the affected by failure to perform administrator and ASM # 2, the director of employee screenings. The nursing, were made aware of the above findings. facility will conduct an audit of 100% of current employee No further information was presented prior to exit. F 226 483.13(c) DEVELOP/IMPLMENT records to ensure that all SS=D ABUSE/NEGLECT, ETC POLICIES sworn statements have been F 226 signed. The facility must develop and implement written (3) ED/designee will educate policies and procedures that prohibit HR Director and management mistreatment, neglect, and abuse of residents team on the policy for and misappropriation of resident property. employment screening prior to hire. The Executive Director or designee will review all new hires during orientation to This REQUIREMENT is not met as evidenced ensure completion of sworn by: statements weekly for four Based on staff interview and facility document review, it was determined that the facility staff weeks and monthly for three failed to implement abuse policies to ensure months. complete a thorough background check for one (4) The Quality of five employee records reviewed, CNA (certified Assurance/Performance nursing assistant) #20. Improvement (QAPI) team will The facility staff did not have a completed, signed conduct periodic audits to sworn statement in CNA #20's employee record identify any noncompliance. prior to the date of hire per the facility abuse policy. Completion Date: 11-7-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/1 STATEMENT OF DEFICIENCIES FORM APPR (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURV COMPLETED 495382 B. WING NAME OF PROVIDER OR SUPPLIER C STREET ADDRESS, CITY, STATE, ZIP CODS 10/06/20-ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX מו PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG Сомац DEFICIENCY) F 226 Continued From page 5 F 226 The findings include: CNA #20 was hired in the facility on 8/8/16. A review of CNA #20's employee record during the survey process revealed, in part, that CNA #20's employee record did not contain a signed/dated sworn statement prior to the date of hire. On 10/6/16 at 12:58 p.m. OSM (other staff member) #18 was asked to provide a copy of CNA #20's sworn statement. On 10/6/16 at approximately 1:15 p.m. OSM #18,

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end of the survey process. F 241 483.15(a) DIGNITY AND RESPECT OF

the sworn statement.

in the presence of ASM (administrative staff member) #1, the administrator, stated that he did not have a signed/dated copy of the sworn statement for CNA #20. OSM #18 further stated that he had a copy on which he had signed but CNA#20 had not signed / dated the form. OSM #18 was asked to describe the process. OSM #18 stated, "Prior to employment I obtain references, a license verification, background check (to include the sworn statement) and a drug screen." When asked if he had followed this process with CNA#20, OSM #18 stated he thought he had but she (CNA #20) did not sign

A review of the facility policy "Resident Abuse" revealed, in part, the following documentation: "Screening: Persons applying for employment with a The (sic) Company facility will be screened for a history of abuse, neglect, or mistreating residents to include: References from previous or current employers (with applicant permission). Criminal Background check. Abuse check with appropriate licensing board and registries, prior to

hire. Sworn Disclosure Statement prior to hire. Verify license or registration prior to hire." No further information was provided prior to the

F 241

Event ID: UQB111

FORM CMS-2567(02-99) Previous Versions Dissolete

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Facility ID: VA0008

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CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF OFFICIENCIES FORM APPROVE (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: A. BUILOING\_ (X3) OATE SURVEY COMPLETEO 495362 NAME OF PROVIOER OR SUPPLIER B. WING C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF OFFICIENCIES ASHLAND, VA 23005 (EACH OFFICIENCY MUST BE PRECEOEO BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) IO PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE CROSS-REFERENCEO TO THE APPROPRIATE TAG DEFICIENCY)

### F 241 Continued From page 6 SS=D INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to promote care in a manner to enhance dignity for two of 32 residents in the survey sample, Residents #15 and #13

- 1. The facility staff failed to provide incontinence care to Resident #15 in a timely manner. CNA (certified nursing assistant) #12 stated she knew the resident was soiled at approximately 10:00 a.m. The CNA did not return to provide incontinence care until 2:14 p.m. Resident #15 stated being left soiled for extended periods of time made her feel angry and sad.
- 2. Facility staff failed to provide incontinence care in a timely manner for Resident # 13. On 10/5/16 at 2:45 p.m. during an interview with Resident #13 regarding her incontinence care Resident #13 stated, "It makes me frustrated and it's unacceptable."

The findings include:

1. The facility staff failed to provide incontinence care to Resident #15 in a timely manner. CNA

F 241

#### F 241

- 1. Incontinence care was provided to resident #13 and #15 during the survey process. Residents #13 and #15 are receiving incontinent care in a timely manner.
- 2. Residents' who reside in the facility have the potential to be affected by not receiving incontinent care. Residents have been observed and staff is responding to calls for assistance and administering incontinent care in a timely manner.
- 3. Staff education has been provided on incontinence care and timely call bell response. Audits to be done 3x a week x1 month and then weekly x2 months on call bell response and providing care by the DCS/designee.
- 4. Director of Clinical Services /designee will report results of findings of audits to the Quality Assurance/Performance Improvement (QAPI) monthly for review and recommendations

Completion Date: 11-7-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495362 B. WING NAME OF PROVIDER OR SUPPLIER 10/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ΙD PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (XE) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 241 : Continued From page 7 F 241 #12 stated she knew the resident was spiled at approximately 10:00 a.m. The CNA did not return to provide incontinence care until 2:14 p.m. Resident #15 was admitted to the facility on 7/10/15. Resident #15's diagnoses included but were not limited to: a fractured vertebra, morbid obesity and diabetes. Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/24/16, coded the resident as scoring a 15 out of a possible 15 on the brief interview for mental status, indicating the resident was cognitively intact. Section G coded Resident #15 as requiring extensive assistance of one staff with bed mobility, locomotion, dressing, toilet use, personal hygiene and bathing. Section H documented the resident was frequently incontinent of bowel and bladder. Resident #15's comprehensive care plan with an implementation date of 9/13/16 documented, "The resident has altered bowel elimination...check resident every approx (approximate) q 2 hrs (every two hours) & PRN (as needed)...Provide pericare after each incontinent episode...The resident has altered bladder elimination...Check for incontinence. Wash, rinse and dry soiled areas..." On 10/4/16 at 1:30 p.m., Resident #15 was observed lying in bed. The resident stated she had been waiting to get her "diaper" changed

since 7:00 a.m. Resident #15 stated "people come in then someone else catches them. I guess they don't have enough staff." The smell of feces and urine was noted in the room. At 1:35 p.m., Resident #15 was asked to ring her call bell.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2016 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING C

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

ASHLAND NURSING AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF OFFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X1) PROVIOER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

495362

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)

(X5) COMPLETION DATE

10/06/2016

### F 241 Continued From page 8

room; however, the resident didn't report to the employee that she needed incontinence care. At 1:50 p.m., Resident #15 was asked why she didn't tell the employee that she needed incontinence care. Resident #15 stated she had never seen that employee. At this time, Resident #15 was asked to ring her call bell and tell staff she needed incontinence care. Resident #15 rang her call bell and CNA (certified nursing assistant) #19 immediately entered the room. Resident #15 told CNA #19 she needed to be changed. CNA #19 stated she would grab some supplies and be right back. At 1:57 p.m., CNA #19 returned to the room and stated she needed to go get help. At 2:01 p.m., CNA #19 returned to the room with CNA #18 and provided incontinence care to Resident #15. Observation of incontinence care revealed Resident #15's entire disposable brief was soiled with urine through the disposable pads underneath the resident. Feces was observed smeared all over the resident's bottom. No open areas were observed on the resident's bottom. CNA #19 asked the resident if she had been washed that morning and the resident stated she had not been touched that day. CNA#18 and CNA #19 were asked who was responsible for caring for Resident #15 that shift. CNA #19 stated CNA #12 was supposed to care for Resident #15. At 2:14 p.m., CNA#12 entered Resident #15's rooms with disposable briefs and pads. CNA #12 placed the supplies in the resident's closet and exited the

On 10/4/16 at 2:30 p.m., an interview was conducted with CNA #18. CNA #18 was asked if the facility employed enough staff to care for residents. CNA #18 stated, "Yes." CNA #18 was asked if she had provided any care for Resident

F 241

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UQB111

Facility IO: VA0008

If continuation sheet Rage 9 of 126

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/20 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILOING \_ COMPLETEO 495382 B. WING NAME OF PROVIDER OR SUPFLIER C STREET AOORESS, CITY, STATE, ZIP COOE 10/05/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 (X4) IO PREFIX SUMMARY STATEMENT OF OFFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE 1X5) CROSS-REFERENCEO TO THE APPROPRIATE TAG COMPLETION OEFICIENCY) DATE F 241 Continued From page 9 #15 that shift (other than the incontinence care F 241 just provided). CNA #18 stated she had not. On 10/4/16 at 2:33 p.m., an interview was conducted with CNA #19. CNA #19 was asked if the facility employed enough staff to care for residents. CNA #19 stated there was enough staff. CNA #19 was asked if she had provided any care for Resident #15 that shift (other than the incontinence care just provided). CNA #19 stated she had only delivered a meal tray to the resident. On 10/4/16 at 2:40 p.m., an interview was

conducted with CNA #12 (the CNA responsible for caring for Resident #15 that shift). CNA #12 was asked to describe the care she had provided for Resident #15 that day. CNA #12 stated she served breakfast, changed Resident #15's brief around 9:00 a.m., put the resident's feet up, and washed the resident. CNA #12 was asked how often Resident #15's brief was changed. CNA #12 stated she checks the resident's brief every hour and a half. CNA #12 stated she checked Resident #15 at "10ish" and the resident was soiled with urine. CNA #12 stated she then became "side tracked" by other residents and confirmed she had not provided care for Resident #15 from "10ish" until she entered the room when this surveyor was observing two other CNAs providing incontinence care to the resident (at approximately 2:14 p.m.).

On 10/4/16 at 2:45 p.m., an interview was conducted with CNA #1 (another CNA working on Resident #15's unit). CNA #1 stated she had not provided any care for the resident during that shift.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18, STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA FORMAPPRO AND PLAN OF CORRECTION OMB NO. 0938-1 IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 10/06/2011 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLET TAG DEFICIENCY) DATE F 241 Continued From page 10 On 10/4/16 at 2:47 p.m., an interview was F 241 conducted with CNA #16 (another CNA working on Resident #15's unit). CNA #16 stated she had not provided any care for the resident during that On 10/4/16 at 4:40 p.m., another interview was

conducted with Resident #15. Resident #15 was asked to describe all of the care that had been provided for her that day. Resident #15 stated someone came into her room at approximately 6:30 a.m. or 7:00 a.m. and asked if she was wet. Resident #15 stated she reported to the woman that she didn't feel anything. Resident #15 stated someone came into her room and brought her meal tray then this surveyor saw all other care provided. Resident #15 was asked how she felt when she was left soiled for an extended period of time. Resident #15 stated that situation didn't happen very often but it makes her wonder why and what had she done. Resident #15 stated she had always been active but there was nothing she could do. Resident #15 stated that makes her feel angry but mostly makes her feel sad.

On 10/5/16 at 9:20 a.m., Resident #15 was lying in bed. CNA #12 entered the room and told the resident she was going to "check her again." After the CNA left the room, Resident #15 stated the CNA stated she was going to care for Resident #15 first each day.

On 10/5/16 at 1:45 p.m., CNA #12 stated during the previous day, she had to serve breakfast in the dining room and had to pass all of the lunch trays on her hall.

On 10/6/16 at 7:52 a.m., an interview was conducted with LPN (licensed practical nurse) #6.

CENTERS FOR MEDICAR STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION DING	PRINTED: 10/ FORM APP OMB NO. 093 (X3) OATE SUR
NAME OF PROMOTE OF	495362	B. WING	_ <del></del>	COMPLETE
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF THE APPEARMENT)	DBE COMP
a.m., and the CNA	how she would feel if she told ed at approximately 10:00 fidn't return to provide	F 24	out loighter)	-RUATE D.
made aware of the a	m ASM#4 (II		4 1 2	
The facility policy title documented in part, " the resident is not der resident's rights may reaction. Waiver of a void. Procedure: Resident's resident is resident's rights may resident is resident is rights may resident is rights may resident.	d, "Resident Rights" The facility will ensure that prived of his/her rights. The not be used as a reward or ny resident rights.		:	
No further information	was presented prior to exit.			
depression, hypertension	that included but were not ery disease (1), on (2), gastroparesis (3), x disease (4), shortness of			
Resident # 13's most re set) a quarterly assessm reference date (ARD) of	cent MDS (minimum data nent, with an assessment 8/18/16, coded the			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

(X1) PROVIOER/SUPPLIER/CLIA

IOENTIFICATION NUMBER:

495362

PRINTED: 10/18/2016 FORM APPROVED (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 A. BUILOING\_ (X3) DATE SURVEY COMPLETED B. WING С STREET ADORESS, CITY, STATE, ZIP COOE 10/06/2016 906 THOMPSON STREET ASHLAND, VA 23005

NAME OF PROVIOER OR SUPPLIER

AND PLAN OF CORRECTION

PREFIX

TAG

## ASHLAND NURSING AND REHABILITATION

SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Ю PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)

IXS) COMPLETION DATE

### F 241 Continued From page 12

resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 13 was coded as being totally dependent of two staff members for activities of daily living and severely impaired of vision.

On 10/5/16 at 8:30 a.m. an observation of Resident #13 was conducted. Resident #13 was observed lying in bed, the head of the bed elevated, a CNA (certified nursing assistant) present on the right side of Resident # 13's bed. The over bed table was on the right side of Resident #13's bed with the breakfast tray on it and the CNA was feeding Resident # 13.

On 10/5/16 at 10:25 a.m. an interview was conducted with Resident # 13. During the interview Resident #13 stated that she required incontinence care. When asked if she had told the staff that needed care, Resident # 13 stated that she had told the CNA who was assisting her with breakfast. Resident # 13 further stated, "I haven't been cleaned up. I told them right after breakfast." When asked who she told about requiring incontinence care Resident # 13 stated, (Name of CNA # 5). It happens all the time, I

On 10/5/16 the following observations were conducted: At 11:00 a.m., CNA #5 walked into Resident # 13's room with chuck pads and supplies for incontinent care. She set them down on the bedside table and left the room. At 11:15 a.m., CNA #5 reentered the room with CNA # 24. They shut the door behind them. At 11:26 a.m. CNA #24 came out of the resident's room. When asked if he was helping with incontinence care for Resident #13, CNA #24, "Yes." At 11:45 a.m.,

F 241

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	Continued From page CNA # 5 exited the resolved linen.	ge 13 oom with a plastic bag of	F 24		

soiled linen.

On 10/6/16 at 9:20 a.m. an interview was conducted CNA # 5. When asked if she assisted Resident #13 with breakfast on 10/5/16, CNA #5 stated, "Yes." When asked if Resident # 13 had told her that she needed incontinence care, CNA # 5 stated, "Yes." When asked what she told Resident # 13, CNA # 5 stated, "I told her [Resident # 13] that I had to feed other residents and should be back after feeding other residents and picking up the trays and I still had to wait for another person because (Resident # 13) requires two to change her." When asked about the condition of Resident # 13 when incontinence care was provided, CNA # 5 stated, "She didn't have a bowel movement but she was wet." When asked about the procedure for incontinence care, CNA # 5 stated, "If the resident is not a two person, check the resident immediately. If the resident requires two people I have to wait for someone else who is available to help."

The comprehensive care plan for Resident # 13 with a review date of 9/8/16 documented, "Category: Elimination GU [genitourinary]. Focus: Resident has altered bladder elimination. Etiologies (causes): Other: specify CKD (chronic kidney disease). Physical limitations. Impaired mobility. Self-care deficit. Incontinence." Under "Approaches/Interventions" it documented, "Check for incontinence. Incontinent brief, pads continually." "Category: ADL (activities of daily living). Focus: Resident has an ADL self-care performance deficit, Etiologies: Limited ROM (range of motion). Musculoskeletal impairment. Disease process (specify) contractures. Medical

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diagr accio contr toilet staff	actures. As e The reside	CVA [cerebral vascular inplegia UE (upper extremity) videnced by: Unable to ent will receive appropriate and mobility, transfer.	F 24			
Resid		o.m. during an interview with ding her incontinence care d, "It makes me frustrated and		· •		
3. What to rece	cted with LPN en asked how ive incontinen	a.m. an interview was (licensed practical nurse) # long a resident should wait ce care LPN # 3 stated, "No nute wait. If you can get in uld be done."				
asked i incontir	now long a res now long a res nence care LPi nmediately. Th	a.m. an interview was f4, unit manager. When ident should wait to receive N#4 stated, "It should be ne resident should not have		; ;		·
membe asked h incontine	ed with ASM (; r) # 2, the dired ow long a resid	m. an interview was administrative staff ctor of nursing. When dent should wait to receive 1 # 2 stated, "A resident mediately."				
auministi	rator and ASM	m., ASM # 1, the # 2, the director of are of the above findings.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING \_ (X3) DATESURVEY COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION) ۱D PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CDRRECTIVE ACTION SHOULD BE CRDSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DEFICIENCY) DATE F 241 Continued From page 15 F 241 References: (1) Common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarte rydisease.html. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. (3) A condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction). This information was obtained from the website: https://medlineplus.gov/ency/article/000297.htm. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (6) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 000726.htm. (7) A swallowing disorder. This information was obtained from the website:

sorders.html.

https://www.nlm.nih.gov/medlineplus/swallowingdi

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF DEFICIENCIES FORMAPPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING \_\_ (X3) DATE SURVEY COMPLETED 495382 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 10/06/2016 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ASHLAND, VA 23005 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CDRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE [X5) COMPLETION TAG DEFICIENCY) DATE F 241 Continued From page 16 (8) Paralysis is the loss of muscle function in part F 241 of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html. F 246 483.15(e)(1) REASONABLE ACCOMMODATION SS=D OF NEEDS/PREFERENCES F 246 Resident #13 has her call bell A resident has the right to reside and receive positioned properly allowing her to call services in the facility with reasonable accommodations of individual needs and for assistance. preferences, except when the health or safety of the individual or other residents would be 2. Residents that reside in this facility endangered. have the potential to be affected by not having call bell access. Observations have been conducted by the DCS throughout the facility and no This REQUIREMENT is not met as evidenced call bells were noted to be out of reach Based on observation, resident interview, staff of residents. interview, facility document review and clinical record review, it was determined that the facility 3. Staff education has been provided on staff failed to place a call ball in an accessible the importance of ensuring call bells place for one of 32 residents in the survey are in reach for all residents. Audits sample, Resident #13. will be conducted daily x1 month and then weekly x2 months to ensure The facility staff failed to position Resident # 13's compliance. adaptive call bell, a Breathcall Cord [call bell activated by a puff of air by the user](1) within 4. Director of Clinical Services /designee will report results of audits to the Quality Assurance/Performance The findings include:

Improvement (QAPI) monthly for

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF DEFICIENCIES FORM APPROVE( (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: A. BUILDING \_ (X3) DATE SURVEY COMPLETEO 495362 B. WING NAME OF PROVIOER OR SUPPLIER C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PRÉFIX (EACH OEFICIENCY MUST BE PRECEOED BY FULL Ю PROVIOER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X3) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OEFICIENCY) F 246 Continued From page 17 F 246 Resident # 13 was admitted to the facility on 1/28/14 with diagnoses that included but were not limited to: coronary artery disease (2), depression, hypertension (3), gastroparesis (4), Completion Date: 11-7-16 gastroesophageal reflux disease (5), shortness of breath, anxiety (6), cerebrovascular disease (7), dysphagia (8), quadriplegia (9) and abnormal posture. Resident # 13's most recent MDS (minimum data set) a quarterly assessment, with an assessment reference date (ARD) of 8/18/16, coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 13 was coded as being totally dependent of two staff members for activities of daily living and severely impaired of vision. On 10/4/16 at 1:45 p.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed slightly raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her chin. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. Resident # 13 was also observed to be able raise her head only slightly, approximately two to three inches from her pillow. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/4/16 at 4:20 p.m. an observation of Resident # 13 revealed she was lying in bed

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	& MEDICAID SERVICES			PRINTED: 10/18 FORM APPRO
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### F 246 Continued From page 18

Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her chin. When Resident # 13 was asked if she could locale and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. Resident # 13 was also observed to be able raise her head only slightly, approximately two to three inches from her pillow. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/5/16 at 9:15 a.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her head. Whan Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call beil. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/5/16 the following observations were conducted: At 10:49 a.m., Resident # 13 was lying supine in the bed and her Breathcall Cord was on the right side of her. The resident could not reach the call bell. At 11:00 a.m., CNA#5 walked into Resident # 13's room with chuck pads and supplies for incontinent care. She set them down on the bedside table and left the room. At 11:15 a.m., CNA #5 reentered the room with CNA # 24. They shut the door behind them. At 11:45 a.m., CNA # 5 exited the room with a plastic bag of soiled linen. At 11:46 a.m., Resident # 13 was observed to be lying in a

F 246

Facility ID: VA0008

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 FORM APPRO STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938-ANO PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: (X3) OATE SURVE A. BUILDING \_ COMPLETED 495382 B. WING C NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 (X4) IO SUMMARY STATEMENT OF OFFICIENCIES PRÉFIX (EACH OFFICIENCY MUST BE PRECEOED BY FULL PROVIOER'S PLAN OF CORRECTION 10 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCEO TO THE APPROPRIATE TAG COMPLE DAT OEFICIENCY) F 246 Continued From page 19

supine position and her Breathcall Cord was out of reach. When asked if she could reach her Breathcall Cord she stated, "I don't think I can reach it."

On 10/5/16 at 1:55 p.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her head. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/6/16 at 8:00 a.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed slightly raised. Observation of the Breathcall Cord revealed the mouth piece missing from the extended arm and was lying on the bed above Resident # 13's right shoulder.

On 10/6/16 at 8:40 a.m. a CNA entered Resident # 13's room and spoke to her about what was going to be served on breakfast tray and then left the room. An observation of the Breathcall Cord immediately after the CNA left the room revealed the mouth piece missing from the extended arm and was lying on the bed above Resident # 13's right shoulder.

On 10/6/16 at 8:45 a.m. a CNA entered Resident #13's room and assisted Resident #13 with breakfast. At 9:00 a.m. the CNA exited Resident # 13's room. An observation of the Breathcall

F 246

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			PRINTED: 10/18/20
STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER'SUPPLIER'CLIA IOENTIPICATION NUMBER	[X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-03
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extended arm and po 13's right cheek. Wh activate the call bell F head to the right push right her right side, pureach. Resident # 13 locate the call bell.  The comprehensive call with a review date of 9 "Focus/Category: Safe "Approaches/Intervent sure the resident's call	er the CNA left the room elece was replaced on the sitioned next to Resident # en asked to locate and Resident # 13 moved her bing the call bell down to the atting the call bell out of her stated that she couldn't	F 246	OCHOICINGY)	NOPRIATE DATE
the television but not the she could see the call be # 13 stated, "No."  On 10/5/16 at 2:45 p.m. conducted with Residen access to the call bell	nt # 13. When asked ent # 13 stated she could shades and the light from e picture. When asked if well to blow into it, Resident an interview was t # 13 regarding her	:		
have to holler for help or coming down the hall an asked how she felt abou access the call bell Resident frustrated."  On 10/6/16 at 9:20 a.m. a conducted CNA # 5. Whas assigned as Resident # 1 from 7:00 a.m. to 2001.	I'll wait for someone I'd cail for help." When It not being able to Ident # 13 stated "I feel I feel			

Facility IO: VA0008

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION OMB NO. 0938-039 IOENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILOING (X3) OATE SURVEY COMPLETED 495352 NAME OF PROVIOER OR SUPPLIER B. WING C STREET ADORESS, CITY, STATE, ZIP CODE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION 10 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE (X5) COMPLETION TAG OEFICIENCY) DATE F 246 Continued From page 21 "Yes." When asked about the call bell for F 246 Resident # 13, CNA # 5 stated, "The call bell should be close to her mouth so she can reach it with her lips and blow into it." When asked if she checked to see that Resident # 13 could reach and activate the call bell before leaving her room, CNA # 5 stated, "No." When informed of the above observations of the call bell being out of Resident # 13's reach on 10/5/15, CNA # 5 stated, "I can't explain why it wasn't in her reach." On 10/6/16 at 10:40 a.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked about the call bell for Resident # 13, LPN #3 stated, "The call bell should be positioned in front of her lips so she can feel it and blow into it. It should be checked for placement every two hours." LPN #3 further stated that Residen! #13 will call out for help. When asked if having Resident #13 call out for help was appropriate, LPN #3 stated, "No. She should be able to use the call bell." On 10/6/16 at 10:45 a.m. an interview was conducted with CNA#4. When asked if she had entered Resident #13's room before breakfast, CNA # 4 stated, "Yes." When asked about the call bell for Resident # 13, CNA # 4 stated, "I didn't notice the mouth piece was missing when I was in the room the first time. When I finished

it."

her breakfast I found it and put it on. I should have checked the call bell before I left. It should be checked every two hours. When asked if she checked that Resident # 13 could locate and activate the call bell before leaving the room, CNA # 4 stated, "I didn't have her try to activate

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/21 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION FORM APPROV IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-03 A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 495362 B. WING C ASHLAND NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/2016 906 THOMPSON STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (5X5) COMPLETION TAG F 246 Continued From page 22 DEFICIENCY) DATE conducted with LPN #4, unit manager. When F 246 asked about the call bell for Resident # 13, LPN # 4 stated, "The call bell should be positioned directly in front of her mouth and they should check the placement before leaving the room." On 10/6/16 at 11:20 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the call bell for Resident # 13, ASM # 2 stated, "It should be checked for placement On 10/6/16 at 11:20 a.m., ASM # 1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. No further information was presented prior to exit. Reference: (1) Breathcall Cord. Pneumatic (operated by air or gas under pressure) call cord uses a non-electric means of activation for patients that are unable to use standard call devices and require minimum exertion. Activation is by a simple puff of air into the device's disposable breath tube. It is equipped with a heavy-duty clamp that is able to mount on virtually any headboard, bed rail or tabletop. This information was obtained from the website: info@criticalalert.com. (2) Common type of heart disease. This information was obtained from the website:

https://www.nlm.nih.gov/medlineplus/coronaryarte

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	100		FO	ED: 10/10 RMAPPR
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https://www.nlm.nih essure.html	.gov/medlineplus/highbloodpr				
(4) A condition that r	educes the ability of the				
a blockage (obstruct	ion) This information				
	ebsite; lov/ency/article/000297.htm,				
(5) Stomach content	s to leak house				
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https://www.nlm.nih.go sorders.html.	olic. V/medlineplus/swallowingdi				
	of muscle function in part s when something goes ssages pass between your				
partial, it can occur on	alysis can be complete or				
	If just one area, or it can				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

PRINTED: 10/18/ FORM APPRO OMB NO. 0938-0 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED B. WING C 10/06/2011

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

ASHLAND NURSING AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

F247

906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

495362

PREFIX TAG

F 246

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

DATE

F 246 Continued From page 24

This information was obtained from the website: https://medlineplus.gov/paralysis.html.

F 247 483.15(e)(2) RIGHT TO NOTICE BEFORE SS=D ROOM/ROOMMATE CHANGE

A resident has the right to receive notice before the resident's room or roommate in the facility is

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide notice prior to a room change for one of 32 residents in the survey sample, Resident #3.

The facility staff failed to notify Resident #3 of a pending room change, and to show him the new room prior to the move on 6/21/16.

The findings include:

Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date 9/4/16, Resident #3 was coded as having no cognitive impairment for making daily decisions.

A review of the social services progress notes for Resident #3 revealed, in part, the following note, written 6/22/16 and signed by OSM (other staff

F 247.

- (1) Resident #3 is pleased with his room assignment.
- (2) ) All residents have the potential to be affected by deficient notification practices. The facility will conduct an audit of 100% of resident medical records to identify those residents who had a room change. Concerns identified will be promptly addressed and as appropriate.
- (3) ED/designee will educate management team of room change policy and resident notification. Social Services will receive all requests for room changes and complete a form to indicate all steps in the protocol are completed. The Executive Director or designee will monitor the forms weekly for a month and monthly for three months.

FORM CMS-2567(02-99) Previous Versions Obsolele

Event ID: UQB111

Facility ID: VA0008

NOV 03 2016

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2016 FORM APPROVED

12 MENT	OF DEFICIENCIES	WEDICAID SERVICES			FORM APPROVE
AND PLAN O	F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILOING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	495362	B. WING	3	С
	ASHLAND NURSING AND REHABILITATION			STREET ADORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET ASHLAND, VA 23005	10/06/2016
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	Continued From pag	ge 25	F 2		

member) #14, the social services director: "It was reported to writer on today that the patient was transferred to [number of new room] due to bed management. Per the admissions coordinator, who contacted via telephone the patient's RP (responsible party)/sister, [name of RP], to get her consent and permission for the room transfer, which the patient's RP did so (sic). Writer spoke with the patient's sister via telephone to confirm that she was made aware of the room transfer that took place on 6/21/16 and the patient's sister confirmed that she was advised of the room transfer and she was in agreement with the room transfer. As noted above, the patient was transferred from [old room number] to [new room number]. SW (social worker) to continue to continue (sic) to monitor patient and provide support. Writer encouraged the patient and his sister to outreach as needed."

A review of the comprehensive care plan for Resident #3 dated 9/16/16 and most recently updated on 9/22/16 revealed nothing related to the resident's room changes.

On 10/6/16 at 9:40 a.m., OSM #14 was interviewed. She stated that residents are moved for "bed management" most often to facilitate appropriate placements for residents being admitted from the hospital (needs to include appropriate gender and isolation status). She stated if a change is needed, the social worker goes to the resident and asks the resident's permission. She stated the social worker also speaks with the RP. She stated the social worker shows the resident the new room, and introduces the resident to the new roommate and new staff (if applicable). She stated these activities are to be documented in the social services progress

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILOING COMPLETED 495362 B. WING C NAME OF PROVIDER OR SUPPLIER 10/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX IX5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 247 Continued From page 26 F 247 notes for the resident. When shown the above-referenced note for Resident #3's move ол 6/21/16, OSM #14 stated: "I did not initiate this room transfer. The admissions coordinator did. She is not here anymore. I don't know what happened. It does not look as though the resident was informed or shown the new room ahead of time." She stated that it's possible that the move occurred after business hours, but she was not certain. She stated that the process she described regarding showing the resident the new room ahead of time should have been followed. On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy entitled "Room Changes" revealed, in part, the following: "Prior to the room change, the team should give the resident/legal representative notice to allow the resident/legal representative time to prepare for the room change. The notice period may be waived by the resident/legal representative. Emergent conditions or safety concerns, as determined by the team, may supersede (sic) the notice period." No further information was provided prior to exit. (1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can

range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease – one in which the body, through its immune system, launches a defensive

91A1CMENT OF DEFICIENCIES	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	100		PRINTED: 10/ FORM APP OMB NO. 093
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clean and maintained in	ed to ensure Resident #3's and a back cushion was a good repair.  ed to provide Resident #14		RECE!	VED 3016

PRINTED: 10/18/;

CENTERS FOR MEDICARE	& MEDICAID SERVICES		P	FORM APPRO
STATEMENT OF OFFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	- 1 22 CONGINGCION	MB NO. 0938-C (X3) OATE SURVE) COMPLETEO
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T TACTA (CAUD DEFICIENTY	MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCED TO THE APPROPE OEFICIENCY)	(X5)

F 252

### F 252 Continued From page 28 with clean fall mats in good repair.

- 3. For Resident #21, the facility staff failed to provide a functioning heating/air conditioning unit and have a window in good repair.
- 4. Facility staff failed to ensure the resident bathroom between rooms 132 and 134 (shared bathroom) was free from a soiled brief on the floor.

#### The findings include:

1. Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, he was coded as having no cognitive impairment for making daily decisions. The resident was coded as using a wheelchair for moving around his room and the unit during the look back period.

On the following dates and times, Resident #3 was observed lying in bed; his motorized wheelchair was located at the foot of the bed: 10/4/16 at 4:10 p.m.; 10/5/16 at 8:30 a.m. and 10:00 a.m. Attempts to interview Resident #3 at these times were unsuccessful. Both the wheelchair armrests were covered with a lamb's wool material. The covering was matted and soiled. The coverings were secured to the arms with duct tape. The tape was chipped and peeling off in places. The back cushion was raw foam rubber with no covering. The foam rubber was soiled and worn.

(2) All residents have the potential to be affected by this deficient practice. The facility will conduct an audit of 100% of wheelchairs for armrests and cushions that need repair or replacement by the Maintenance Director or designee. 100% audit of the fall mats that need to be replaced will be conducted by the Housekeeping Supervisor designee. 100% audit of HVAC units and windows for function and repair by the Maintenance

Director or designee. 100%

Housekeeping Supervisor or

designee. Concerns identified

as appropriate, reported to the

QA/I team for follow through.

will be promptly addressed and

cleanliness by the

audit of resident bathrooms for

(3) The facility will (a) review/revise/enforce/monitor its policies & procedures ensuring maintenance and cleanliness of the facility. (b) In-service staff on the Maintenance Log and policies around maintenance of the facility (c) Staff making rounds will complete Maintenance work orders as

CENTERS FO	<u>JR MEDICARI</u>	& MEDICAID SERVICES				PR	RINTED: 10/18/201 FORM APPROVE
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NAME OF PROVID	ER OR SUPPLIER	495362	B. WING		<del></del> _		С
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F 252 Contir			F2	52	OLI ICIBAÇY)		
nursin	g assistant) #1	a.m., LPNs (licensed and #10, and CNA (certified 4, accompanied this					

On 10/6/16 at 10:30 a.m., LPNs (licensed practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied this surveyor to look at Resident #3's wheelchair. When asked to describe the armrests, LPN #14 stated: "It needs new arms." LPN #14 stated: "It is nasty looking." All three staff members agreed that the back cushion should have a cover, both for appearances and for comfort for the resident. When asked if the wheelchair looked home-like and clean, they stated that it did not. LPN #10 stated that she would notify therapy services to replace the armrest covers and the back cushion immediately.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Equipment Repairs" revealed, in part, the following: "All equipment in need of repair is returned to the vendor or manufacturer. We do not repair equipment. It is replaced."

No further information was provided prior to exit. (1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body, through its immune system, launches a defensive attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus."

needed. Maintenance will complete items from the Maintenance log and turn into the Executive Director or designee to sign and monitor weekly for three months. Maintenance and Housekeeping staff will monitor facility audit of designated areas weekly for three months

(4) The Quality
Assurance/Performance
Improvement (QAPI) team will
conduct periodic audits to
identify any noncompliance.

Completion Date: 11-7-16

CENTERS FOR MEDICAL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				PRINTED: 10/18/ FORM APPRO OMB NO. 0938-( (X3) DATE SURVEY		
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On was obse side 7:35 obse chip	the following dates observed lying in herotalions, fall mats s of his bed: 10/4/2 a.m., 8:30 a.m., arevations, the gray for the state of the state o	and times, Resident #14 ils bed. On all were present on both 6 at 4:30 p.m.; 10/5/16 at all mais were dirty, spatters of white paint							
nursi surve Whe	eyor to look at Resid asked to describe	d #14 and CNA (and to )							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/ FORM APPRO STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING \_\_ COMPLETED 495362 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/2018 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE PREFIX . (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 252 Continued From page 31 the white blotches as "old paint" and stated the F 252 mats should be changed. On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) "COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topic s/copd. 3. For Resident #21, the facility staff failed to provide a functioning heating/air conditioning unit and have a window in good repair. Resident #21 was admitted to the facility on

and alcohol abuse.

10/21/15 with diagnoses that included but were not limited to: high blood pressure, dementia, depression, PTSD (post-traumatic stress disorder) chronic pain, neuropathy, chronic pain,

The most recent MDS (minimum data set)

PRINTED: 10/18/2016 FORM APPROVED

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F 252 Continued From pa	age 32						
assessment refere	nce date of 9/20/46	F 25	2				
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. status / Store of 10.	Undication be wise moderntal						
impaired to make o	Idlly coontive decisions The						
eating after set up	l as requiring supervision for			:	l		
required limited ass	assistance was provided. He sistance for moving on and off				1		
the unit, and extens	IVE assistance for bod						
mobility, transfers, o	dressing, toileting and						
personal hygiene.	-						
On 10/6/16 at 8:20	a.m. observation was made of						
Resident #21's room	n. The heating/air conditioning						
unit under the windo	W was observed uppluaged 7						
and without coultof 8	(nobs. The heating/air						
corraitioning unit was	S off the wall approximately						
one mon, when ask	ed if his room was						
adjust the temperatu	nt #21 stated, "No, I can't re. It blows cool air." When						
asked it he had told :	anvone Resident #24 -+		•				
r tota the nurses," v	Vinen asked if he good to						
activities, Resident #	21 Stated "No I sit become			1			
watch the bugs crawl window."	through the broken						
window.							
The window was obs	erved. The window frame						
was raped with simmli	num duct fang down the				Ì		
center where the two	Windows meet It was tanget						
SO THE MINDOMS COMIC	NOT be opened At the						
where the two window	ndow frame, in the center						
approximately one ou	vs met, there was a gap of arter of an inch where the						
eage of the glass was	Dulled away from the						
window frame and air	was noted to come in from				İ		
the outside. Four and	a half dead bugs were						
observed on the windo	ow ledge.						
On 10/6/16 at 8:33 a.n	n OSM/othorates						
member) #1, the main	tenance director was						
77	- Stration differential was				[		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/2016 FORM APPROVED STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938-0391 ANO PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: (X3) OATE SURVEY A. BUILOING COMPLETEO 495362 C B. WING NAME OF PROVIOER OR SUPPLIER 10/06/2016 STREET AOORESS, CITY, STATE, ZIP COOE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 O1 (4X) SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEOEO BY FULL PRÉFIX Ol PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX (X5) COMPLETION TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 252 Continued From page 33 F 252 shown Resident #21's room. When asked the process for identifying maintenance concerns, OSM #1 stated, "I just started in this position in July of this year. We do mock survey rounds every morning. There is a maintenance log on each unit. There is a maintenance person for each unit." When shown Resident #21's room, OSM #1 stated he was not aware of the heating/air conditioning unit being in disrepair and was not aware of the window. The maintenance log book for the unit Resident #21 resided in was reviewed with OSM #1. The only maintenance repair requested was dated, 7/21/16. The "Repair Requisition" documented, "Both cont (control) knobs on A/C (air conditioning) are missing." At the bottom of the requisition form it was documented, "Replaced both knobs with new ones." There were no further requests for maintenance for Resident #21's room. OSM #1 was asked to check the temperature of Resident #21's room. The room temperature was read as 73.5 degrees. At 8:54 a.m. maintenance was in the room to put on new knobs and secure the unit to the wall. When OSM#1 asked the resident if he wanted heat or air conditioning, Resident #21 stated, "I need the heat on, it's cold in here." An interview was conducted with LPN (licensed practical nurse) #1, on 10/6/16 at 9:29 a.m. LPN #1 was asked how a nurse would report something that was broken or in need of repair in a resident's room. LPN#1 stated, "We have a maintenance log book and we fill in the slip. If its emergent you can call them (maintenance)." When asked if anyone can write in the maintenance book, LPN #1 stated, "Yes, anyone

can write in in,"

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO	JLTI OIN	FORMAPE OMB NO. 093 (X3) DATE SUR		
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-02 CONT	inea Liotti ba	age 34	F 2	52			
: nursir : CNA ±	iy assistant) #	#1 on 10/6/16 at 9:32 a.m.		.0_	_		
somet	hina in need	what she does if she finds of repair in a resident's room.					,
100100	nts salety. T	Den either call mainte					
	mergent, put	it in the maintenance log					
book."		109					
The fac	cility noticy "A	Maintage n					
part. "7	The Director o	Maintenance" documented in of Environmental Services will					
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PC1100 01	mine, lite Office	JINAIOr Will be notified I					
the curre	nt status and	further resolution."					
1							
concerns	on10/6/16 at	made aware of the above 9:20 a.m.					
No furthe	r information	was provided prior to exit.					
4. The fac	cility staff faile	d to ensure the resident					
DG [11] OO[1]	nerweet too.	MS 132 and 1977accor					
bathroom floor	) was free fro	m a soiled brief on the					

floor.

CENTERS FOR MEDIC	ARE & MEDICAID SERVICES			PRINTED: 10/18/2011 FORM APPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) OATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPL	495362 JER	B. WING		С
ASHLAND NURSING AND		90	REET ADDRESS, CITY, STATE, ZIP CO 6 THOMPSON STREET	1 10/06/2016 DDE
(X4) ID SUMMARY PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES	ID AS	SHLAND, VA 23005	
/ · //5/ // (C//C/) DELICIE	COULDELICIENCY MUST BE DRECEDED BY EACH		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	
F 252 O		T		

### F 252 Continued From page 35

F 252

On 10/4/16 at 1:25 p.m., tour of the facility was conducted. At 1:30 p.m., the bathroom in between rooms 132 and 134 was observed to have a soiled brief on the floor in the corner.

On 10/4/16 at 2 p.m., the soiled brief was observed on the floor in the comer of the bathroom in between rooms 132 and 134.

On 10/4/16 at 2:45 p.m., a housekeeping staff member, (OSM (Other Staff Member) #15) was in front of room 132. He was observed starting to mop the floor until he noticed the soiled brief. He alerted a CNA who worked that section to pick up the spiled brief. At 2:55 p.m., the CNA who worked that section disposed of the soiled brief.

On 10/4/16 at 2:55 p.m., an interview was conducted with OSM #15. When asked how often he rounded on resident rooms to clean, OSM #15 stated that he mops and cleans every room after breakfast and before lunch so that cleaning supplies are not on the floor when meal trays are being served. When asked who was responsible for ensuring dirty items like briefs are picked up off the floor, OSM #15 stated that if he sees items like soiled briefs, he will tell the nursing staff. OSM #15 stated that he cannot pick up soiled briefs and put them in his trash because he has to travel to every resident room with his cart. When asked if he saw the soiled brief in the bathroom in between rooms 132 and 134, OSM #15 stated that he did. OSM #15 stated that as soon as he saw the brief, he told the CNA and she picked the brief up off the floor. OSM #15 stated soiled briess should not be on the floor due to contamination.

Continued From page 36  On 10/4/16 at approximately 3:15 p.m., an interview was conducted with CNA (certified nursing assistant) #23. When asked how often CNAs rounded on resident rooms, CNA #23 stated that she rounds every 1-2 hours. When asked what rounding included, CNA #23 stated that it included checking on the resident to see if they are soiled, to see if they are having any unusual behaviors, making sure residents are safe, and to make sure rooms are clean. When asked if resident bathrooms are included during the rounding process to ensure they are clean, CNA #23 stated that resident bathrooms were included. When asked if soiled briefs should be left on the floor of a resident's bathroom, CNA #23 stated that soiled briefs should be left on the floor of a resident's bathroom, CNA #23 stated that soiled briefs should be left on the floor of a resident's bathroom, CNA	938.
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#40 Stated that solled briefs should not be an u	
11001. CNA #23 SIGIED that it was the purples of the	
that is responsible for picking up soiled items like linen and briefs.	
mon and briefs.	
On 10/5/16 at 10:25 a.m., an interview was	
CONDUCTED WITH CINA #12 The CNA when we	
4551911E0 to rooms 132 and 134 pp 10/4/46	
Varieti dakeu NOW Offen (INAs rounded en	
resident rooms, CNA #12 stated that she rounded every hour and a half. When asked what	
rounding included. CNA #12 stated that it	
Included changing residents or toileting the	
TOUNITY to see if ped or chair alarme are in the	
making sole Call Dells are in reach, and to an - in	
rooms are clean. When asked if cleanliness of rooms included the resident's bathroom, CNA #12	
Stated trial 18310801 S DRIBTOOMS word included	
and were checked for trash, cliffer and items are	
THE GLOUID. MAREN ASKED IT She was the CMA	
picked up the ulfly Drief in the hathroom habitage	
rouns 132 and 134. CNA #12 stated that abo	
was. When asked if dirty briefs should be on the floor, CNA#12 stated. "No hecause of	

### DEPARTMENT OF HEALTHAN, HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/2016 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495362 B. WING С NAME OF PROVIOER OR SUPPLIER 10/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE [X3] CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DEFICIENCY) F 252 Continued From page 37 contamination." CNA#12 could not recall the last F 252 time she was in that bathroom but stated that they have residents who take off their briefs and throw them on the floor. On 10/5/16 at 5:11 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings. Facility policy titled, "Guidelines for Disposable Resident Care Items" did not address how to dispose of soiled briefs or rounding on resident rooms. No further information was presented prior to exit. F 253 : 483.15(h)(2) HOUSEKEEPING & F 253 SS=E MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a F 253, 12VAC5-371-370 sanitary, orderly, and comfortable interior. (1) Ceiling tiles in rooms 100, 112 and 120 were replaced. This REQUIREMENT is not met as evidenced Floor tiles in room 113 and 200 were repaired. The bottom of bv: Based on observation and staff interview, it was the door in room 202 was determined that the facility staff failed to maintain painted. The wall in room 138 resident rooms in good repair in eight of 98 was painted. In room 301 the resident rooms, (Resident rooms # 100, # 112, # wall under the sink was 113, #120 #138, #200, #202, and #301). repaired and painted, the bottom of the wardrobe was The facility staff failed to maintain resident rooms repaired, the scrape on the # 100, # 112, # 113, # 120 # 138, # 200, # 202, wall was repaired and painted

like environment.

The findings include:

and #301 in a condition of good repair and home

and the cable wire in the wall

was covered by a wall plate.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18, STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA FORM APPRO AND PLAN OF CORRECTION OMB NO. 0938-I IOENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING\_ (X3) OATE SURVE COMPLETEO 495362 NAME OF PROVIOER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP COOE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF OFFICIENCIES ASHLAND, VA 23005 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 10 PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULO BE TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLÉ DATE OEFICIENCY)

## F 253 Continued From page 38

Observations during the days of the survey revealed ceiling tiles with brown stains in resident rooms # 100 (five tiles), # 112 (one tile near the bathroom door), and resident room # 120 (four tiles). At the doorways to resident rooms # 113 and #200 the floor tile was missing pleces. Resident room # 202 had paint scraped off the bottom of the room door and the door frame. In room #138 the paint on the wall inside the door was scraped and peeling. In resident room #301 under the sink to the left the wall is deteriorating, the cove base (baseboard) is coming off the wall, and the bottom of the wardrobe is deteriorating Continuing in resident room #301 behind the "B" bed the paint is scraped off the wall. Next to the "A" bed there is a wire coming out of the wall (this was identified by OSM (other staff member) #1, director of maintenance, as the cable for the television.)

On 10/6/16 beginning at approximately 9:00 a.m. an observation of resident rooms # 100, # 112, # 113, # 120 # 138, # 200, # 202, and # 301 was made with OSM # 1, OSM # 5, the director of housekeeping, and OSM #6, the area manager. OSM #1 stated that staff do rounds every morning and then report any issues at the morning meeting. OSM #1 stated that he was aware that there was an issue with the roof and that the stained ceiling tiles are a result. OSM#1 stated that the facility was working on getting the roof repaired. At this time a request was made for any documentation of the roof issue. For the wire in resident room #301 next to the "A" bed that was identified as a television cable wire, OSM #1 stated that the resident had pulled it out of the wall and that he (OSM # 1) would have his staff push it back into the wall and put a wall plate

F 253

- (2) All residents have the potential to be affected by inadequate facility maintenance. The facility will complete a 100% audit of all rooms to identify needed repairs. Any deficiencies will be addressed immediately.
- (3) ED/designee will educate maintenance team and other management staff on the facility policies & procedures ensuring maintenance of the facility. ED will make weekly rounds x 3months with the maintenance director to ensure facility is clean and equipment is functional. The maintenance log will be reviewed 5x weekly for 1 month to ensure

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IN AND HUMAN SERVICES  ARE & MEDICAID SERVICES  (X1) PROVIOER/SUPPLIER/CLIA	(Y2) Mu Tu		PRINTED: 10/18/2 FORM APPROV
	IOENTIFICATION NUMBER:	A. BUILOING	PLE CONSTRUCTION G	OMB NO. 0938-0 (X3) OATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIE	495362 ER	B. WING		C
ASHLAND NURSING AND F	REHABILITATION	,	STREET AOORESS, CITY, STATE, ZIP COOE 905 THOMPSON STREET	10/06/2016
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F 253 Continued From p	age 39		an outro	
the resident rooms	was also at this time asked for any of the items identified in SM#1 was asked for the	F 253		
facility policy on m	aintenance repairs. A request			
asked how maintan	on 10/5/16 at 11:25 a.m. with ical nurse) # 2, LPN # 2 was ance issues are		compliance with repairs then weekly x 1 3 month	and as.
stated that if there a need to be repaired maintenance crew what hallway. LPN # 2 full maintenance departs	e maintenance staff. LPN # 2 re any issues with items that one can just grab one of the		(4) The Quality Assurance/Performance Improvement (QAPI) tea conduct periodic audits to identify any noncomplian	m wili
During an interview of	ng repairs completed.		Completion Date: 11-7-16	
was asked how main communicated to the stated that staff can jut they come and take communication bookmaintenance comes to you they can just look stated the maintenance	tenance issues are maintenance staff. CNA # 2 ust page maintenance and are of the issues; CNA # 2 if can write the issue in the that way when the unit if they cannot find in the book. CNA # 2 e staff is excellent.			
issues are communical staff. LPN # 1 stated the also staff can call the	10/6/16 at 8:25 a.m. with asked how maintenance ed to the maintenance lat there is a log book and aintenance department put the request in the log			

but staff should always put the request in the log book too. LPN#1 stated that maintenance is

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201: FORM APPROVEL STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495362 B. WING С NAME OF PROVIDER OR SUPPLIER 10/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 253 Continued From page 40 F 253 During an interview on 10/6/16 at 10:10 a.m., ASM (administrative staff member) # 1, the administrator, was made aware of these observations and a request for any policies was made at this time. An opportunity was given to present any documentation that was available.

Review of the facility "Maintenance" policy presented by ASM # 4, Regional director, on 10/6/16 at 1:10 p.m. documented the following: under "Policy" "The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair." Under "Procedure: The Director of Environmental · Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form (Attachment A). The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and further resolution."

No further information was provided by the end of the survey.

	OF DEFICIENCIES	E & MEDICAID SERVICES	<del></del>	<del></del>	FORM	): 10/18/2 1APPROV
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	. 0938-0. FE SURVEY
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F 278 - A	483.20(g) - (j) ASSE ACCURACY/COOR	SSMENT DINATION/CERTIFIED	F 27			
ָ ד	The assessment mu	st accurately reflect the		F278		
•	coldent's status.			(1)Resident #1 has	been	
A	registered nurse m	ust conduct or coordinate		interviewed by Soc	ial Work.	
-	ach assessment wit articipation of health	n the appropriate		(2)All residents with	nin the	:
А	registered nurse m	unt simo - I		facility have the pot	ential to be	
a	ssessment is compl	ust sign and certify that the eted.		affected by failure t MDS assessments	o complete completely.	
a	ach individual who c ssessment must sign at portion of the ass	completes a portion of the name and certify the accuracy of essment.		(3) The facility's Poi Procedures related appropriate complet	to the	
***	אווט אוווע אוויט איייי	Medicaid, an individual who ceriifies a material and sident assessment is		MDS processes will reviewed relative to manual. Appropriate	be the RAI	
\$1	,000 for each asses	y penalty of not more than		Policies/Procedures	ng said and the	i
to	"dily and knowingly Certify a majerial and	causes another individual		importance of compl MDS coordinator wil	ianco	i
pei	nalty of not more that sessment.	s subject to a civil money an \$5,000 for each		ensure MDS assessi complete	onths to nents are	:
Clir ma	nical disagreement o teriat and false state	does not constitute a ement.		4. Compliance will be monitored via the Que Assurance Performant (OAD).  Improvement (OAD).	ality	:
υy.		s not met as evidenced		Improvement (QAPI) Results will be report monthly QAPI meetin	ed at the	
1 0111	incomercial review a	v, facility document review and in the course of		appropriate.		
the t	ipialit investigation, facility failed to main Frate NtDS (minimum	it was determined u .		Completion Date: 11-	7-16	

Facility ID: VACCOS

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 STATEMENT OF OFFICIENCIES FORM APPRI (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-(X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: A. BUILOING \_ (X3) DATE SURVI COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (X4) ID (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PRÉFIX IO PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5 COMPLE TAG DEFICIENCY) DAT F 278 Continued From page 42 Resident #1. F 278 The facility staff failed to attempt an interview with Resident #1 to complete Section C, Cognitive Patterns, on Resident #1's quarterly assessment with an ARD (assessment reference date) of 7/27/16. The findings include: Resident #1 was admitted to the facility on 10/29/15 with diagnoses that included, but were not limited to; cerebral infarction (injury to the brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and asthma (a disease of the lungs). The most recent MDS assessment was a significant change assessment with an ARD of 8/19/16. On the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns. Resident #1 was coded as a three out of a possible 10 indicating that Resident #1 was significantly impaired with cognitive skills for daily decision making. Section B, Hearing, Speech and Vision, coded Resident #1 as sometimes understood and usually understands.

usually understands.

Section C of Resident #1's quarterly MDS with an ARD of 7/27/16 documented, "C0100. Should Brief Interview for Mental Status be Conducted? -Attempt to conduct interview with all residents." A "0" was entered indicating that resident was unable to complete an interview. A staff assessment was conducted and completed. Section B, Hearing, Speech and Vision, coded Resident #1 as sometimes understood and

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	& MEDICAID SERVICES			PRINTED: 10/18/ FORM APPRO
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	OMR NO. 0939-0
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NAME OF PROVIDER OR SUPPLIER	10002	B. WING		С
ASHLAND NURSING AND REL	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET	10/06/2018
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES		ASHLAND, VA 23005	
	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDENCE DI AMOS	
F 278 Continued From page	- 12		Jan Maria	

## F 278 Continued From page 43

On 10/4/16 at 4:15 p.m. Resident #1 was observed lying in her bed, watching the television. When this surveyor entered Resident #1's room she smiled and when asked how she was Resident #1 did not speak but did put a thumbs up, indicating all was well.

On 10/5/16 at approximately 11:00 a.m. an interview was conducted with OSM (other staff member) #14, the social worker. OSM #14 was asked to state the sections of the MDS that she was responsible for completing. OSM #14 stated that she was responsible to complete Sections C, D, E and Q. OSM #14 was asked whether or not she interviewed the residents to complete any of those sections. OSM #14 stated, "I do resident interviews for Sections C and D." OSM #14 was asked whether or not there were any situations that would prevent her from attempting to interview a resident for those sections. OSM #14 Stated, "We always attempt to conduct an interview, if the resident is nonverbal then we move to the staff assessment." OSM #14 was asked under what circumstances an interview would not be attempted to complete Sections C and D. OSM #14 stated, "We would not attempt an interview if the resident was in a vegetative stated." OSM #14 was shown Schedule C of Resident #1's MDS assessment with an ARD of 7/27/16 and asked whether or not an interview was attempted on Resident #1. OSM #14 stated, "I did not do that MDS assessment but an interview should have been attempted, the coding is incorrect, the response should have been "1" (one) and then we could move to the staff assessment." OSM #14 was asked what she used as a reference guide to complete the MDS sections that she was responsible for. OSM #14 stated, "I refer to the RAI (resident assessment

F 278

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/2011 STATEMENT OF OFFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 ANO PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILOING (X3) OATE SURVEY COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 905 THOMPSON STREET SUMMARY STATEMENT OF OFFICIENCIES ASHLAND, VA 23005 (X4) 10 (EACH OEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IOENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULO BE [X5) COMPLETION CROSS-REFERENCEO TO THE APPROPRIATE TAG DATE OEFICIENCY) F 278 Continued From page 44 instrument) to complete my MDS sections." F 278 An end of date meeting was conducted on 10/5/16 at 5:15 p.m. with ASM (administrative staff member) #1, the administrator, and ASM #4, the regional director of nursing services. ASM #1 and ASM #2 were made aware of the above findings, No further information was provided prior to the F281 end of the survey. F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET 1. Resident #3 is wearing knee braces SS=D PROFESSIONAL STANDARDS as tolerated per MD order. The services provided or arranged by the facility 2. Residents with orders for assistive must meet professional standards of quality. devices have the potential to be affected. DCS conducted This REQUIREMENT is not met as evidenced observations of residents with bv: assistive devices and none were Based on observation, staff interview, facility found to be out of compliance with MD document review and clinical record review, it was determined that the facility staff failed to order. follow professional standards of practice for one 3. Staff education has been provided to of 32 residents in the survey sample, Resident staff on following MD orders. Weekly #3. audits to be conducted on following The facility staff signed off physician-ordered md orders for assistive devices x3 knee braces as though the orders were followed months to ensure compliance. for Resident #3 on 10/5/16. Observation revealed that the braces were never applied that 4. Director of Clinical Services /designee day. will report results of audits to the

The findings include:

Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on

11/13/15, with diagnoses including, but not limited

Quality Assurance/Performance Improvement (QAPI) monthly for

Completion Date: 11-7-16

review and recommendations

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/18/2016 FORM APPROX

STATEMENT	(S FOR MEDICAR) OF DEFICIENCIES	E & MEDICAID SERVICES			FORM APPROVE
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY
NAME OF P	ROVIDER OR SUPPLIER	495362	B. WING		COMPLETED
ASHLAND (X4) IO	NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	10/06/2016
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F 281 (	Continued From pag	ge 45	E 26		

to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, Resident #3 was coded as having no cognitive impairment for making daily decisions. He was coded as being functionally limited in range of motion on both sides of his lower extremities (legs), and as having received restorative nursing services for passive range of motion and bed mobility during the look back period.

On 10/5/16 at 8:30 a.m., 10:00 a.m. and 1:30 p.m., Resident #3 was observed lying in bed; he did not have a knee braces applied. Both of Resident #3's knees were bent, and his lower legs were pulled up close to his upper legs in contractures Attempts to interview Resident #3 at these times were unsuccessful.

A review of the physician order sheet for Resident #3 revealed the following order, most recently signed by the physician on 9/27/16: "Patient to wear knee brace to both knees daily from 8am (8:00 a.m.) to at 2:00 p.m. (sic) - Please check skin before applying and after removing brace."

A review of the TAR (treatment administration record) for Resident #3 revealed nurses' initials in the boxes indicating the knee braces were applied and removed as ordered on 10/5/16.

A review of the comprehensive care plan for Resident #3 dated 9/16/16 and most recently updated on 9/22/16 revealed, in part, the following: "Bilateral knee braces as ordered."

On 10/6/16 at 10:10 a.m., LPN (licensed practical

F 281

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/20: STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILOING (X3) OATE SURVEY COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING С STREET ADORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEOED BY FULL PREFIX ΙD REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE TAG (X.5) COMPLETION DATE OEFICIENCY) F 281 Continued From page 46 nurse) #10 was interviewed. She stated that F 281 Resident #3 refused to have the knee braces applied earlier that morning (10/6/16). When asked if Resident #3 frequently refuses the knee braces, LPN #10 stated: "He is more likely to refuse them if he is not up in his wheelchair." When asked if the resident's refusals should be documented, LPN #10 stated: "Yes. It should be circled on the TAR and documented in the nurses notes or the back of the TAR." When shown the TAR for 10/5/16, LPN #10 stated; "It looks like the braces were put on and taken off like the order says to do." When informed of the surveyor's observations on 10/5/16, LPN #10 stated: "You should not ever sign off that something was done if you don't know for sure it was done, or if you know for sure it wasn't done." When asked why Resident #3 has the knee braces ordered, LPN #10 stated: "He has really bad contractures. The braces help keep them from getting worse." On 10/6/16 at 10:35 a.m., CNA (certified nursing assistant) #14 was interviewed. She stated that she is the aide who provides restorative nursing services to residents, including Resident #3. She stated that she never applies the knee braces. She stated she was not even aware that Resident #3 had an order to wear knee braces. She stated she occasionally works with the resident on passive range of motion and bed mobility. She stated she did not recall a time when Resident #3 had been wearing knee braces. On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 STATEMENT OF DEFICIENCIES FORM APPRO (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURVE COMPLETED 495362 B. WING NAME OF PROVIDER OR SUPPLIER С STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ĮX5 TAG DATI DEFICIENCY) F 281 Continued From page 47 Orders" revealed no information related to F 281 accurate nursing documentation in following physicians' orders. No further information was provided prior to exit. (1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body, through its immune system, launches a defensive attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus." This information is taken from the website http://www.ninds.nih.gov/disorders/multiple\_scler osis/multiple\_sclerosis.htm. (2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement. The following quotation is found in Potter and Perry's Fundamentals of Nursing, 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/ STATEMENT OF DEFICIENCIES FORM APPRO (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURVE COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING C STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/2011 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX JĐ PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) TAG DATE DEFICIENCY) F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED SS=D PERSONS/PER CARE PLAN F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to follow the written plan of care for three of 32 residents in the survey sample, Resident #'s 11, 13, and 3.

- The facility staff failed to follow the care plan and administer antibiotics per physician's order for Resident #11 on 9/28/16 through 9/30/16, 3-11 shift.
- 2a. The facility staff failed to provide bilateral (right and left) hand splints as documented in the comprehensive care plan for Resident #13.
- b. Facility staff failed to position the adaptive call bell, a Breathcall Cord (1) within reach as documented in the comprehensive care plan for Resident # 13.
- 3. The facility staff failed to apply knee braces to Resident #3's bilateral knees per the comprehensive care plan and physician orders.

The findings include:

 Resident #11 was admitted to the facility on 7/15/15 with diagnoses that included but were not

### ---

- 1. Resident #11 did not have any adverse affects due to missed medication doses. Resident #13 is wearing hand splints as ordered and documentation is accurate. Resident #13 call bell is positioned properly within reach. Resident #3 is wearing knee braces as tolerated per MD order and documentation is accurate.
- 2. Residents that reside in the facility have the potential to be affected by failure to follow Physician orders and failure to have call bell access. DCS reviewed Physician orders written over past 30 days and interviewed residents and none reported not receiving medications. Observations were made and found that devices were applied as ordered by Physician and call bells were observed to be within reach.

CENTERS FOR MEDICARE & MI STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION  (X1) F		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			PRINTED: 10 FORM AP OMB NO. 09	
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docu	mented the me	edication was effective.					
A phy	/sician's order	dated 8/22/16 documented an		-			
	Andrie of Gel fitt	scheduled oxycodone 10 mg					
every	four hours.						
A phy	sician's note d	ated 8/25/16 documented,					
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On 10	/6/16 at 11:10 a	a.m., a telephone interview					
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#23's N	dS Contin. OS	ny prescriptions for Resident					
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Оп 10/6	/16 at 1:00 p.m	., ASM (administrative					
aran III6	11106(1 #/ (the t	TITECTOR of public \					
made av	vara or me soo	Ve Indinge This					
: radnasie	in to sheak to b	Resident #23's physician to			*		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE	& MEDICAID SERVICES		PRINTED: 10/18 FORM APPRO
STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938- (X3) DATE SURVE COMPLETED
NAME OF PROVIDER OR SUPPLIER	495362	B. WING	С
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### F 385 Continued From page 100

obtain darification as to why the physician didn't address the insurance concern regarding the resident's MS Contin when notified on 8/14/16 (per the nurse's note) and why the pain medication wasn't addressed until 8/22/16 when the resident's MS Contin was discontinued and oxycodone was scheduled. ASM #2 stated Resident #23's physician was out of the country during that time period and she (ASM #2) couldn't identify which physician the nurse spoke to on 8/14/16. ASM #2 stated she would contact Resident #23's physician.

On 10/6/16 at 2:25 p.m., a telephone interview was conducted with ASM (administrative staff member) #5 (Resident #23's physician). ASM #5 was made aware of the above findings. ASM #5 stated he wanted to put Resident #23 on long acting pain medication and insurance wouldn't pay for that type of medication but the resident was already receiving as needed oxycodone. ASM #5 stated, "If insurance doesn't pay what can we do?" ASM #5 was asked if he received a prior authorization regarding the resident's MS Contin. ASM #5 stated he couldn't remember if he filled one out. ASM #5 stated the resident wanted pain medication that wasn't covered by insurance so he (ASM #5) had to cancel the MS Contin order and schedule oxycodone. When asked why this wasn't addressed or done between 8/14/16 and 8/22/16, ASM #5 stated, "I don't know. I don't know what to say."

On 10/6/16 at 2:26 p.m., ASM #2 was made aware of the above findings.

On 10/6/16 at 3:18 p.m., another interview was conducted with ASM #5 ASM #5 stated he wanted to put Resident #23 on long term pain

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2016 FORM APPROVED OMB NO 1938-1391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA	(X2) M(III)	ID: F	00010	OMB NO. 0938-0
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medication but the recover that type of me Fentanyl made the reinsurance didn't cover	esident's insurance didn't edication. ASM #5 stated	F 38	5		
severe pain. This info the website: https://dailymed.nlm.r	n was presented prior to exit. ated for the management of ormation was obtained form ih.gov/dailymed/drugInfo.cf F44-42E2-9B75-37B2E9FF		:		·
(2) Oxycodone is used information was obtain https://dailymed.nlm.nim?setid=5999f3c3-32287	to treat pain. This ned from the website: h.gov/dailymed/drugInfo.cf 25-4d24-82cd-0b8d7a3095				
(3) Quadriplegia is part This information was o https://medlineplus.gov	alysis of the arms and legs. btained from the website: /paralysis.html				
https://dailymed.nlm.nil	sed to treat chronic pain. otained from the website; o.gov/dailymed/drugInfo.cf f-412a-8fbf-617f6a4f91ed G RECORDS,	F 431			
The facility must employ a licensed pharmacist wo of records of receipt and controlled drugs in suffice	or obtain the services of the object of the			All controlled drugs are sto double locks on 3/3 units in No residents were affected deficient practice.	the facility
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c	controlled drugs is neconciled.	naintained and periodically	F 43	31 : :			
prince and a control of the control	professional principle propriate accessor structions, and the pplicable.  In accordance with Sacility must store allocked compartments portrols, and permit of ave access to the key access to the key prover an entity affixed comprehensive Drug portrol Act of 1976 are takened true distributed for the provention of the	ry and cautionary expiration date when  tate and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to		4	B. Staff has been educated maintaining controlled d double locked procedure conducted daily x1 mon weekly x2 months of loc drug storage system to ecompliance.  Director of Clinical Servi will report results of audi Quality Assurance/Perfolmprovement (QAPI) moreview and recommendate Completion Date: 11-7-16	rugs behi e. Audits i th and the ked contr ensure ces /desiq its to the rmance enthly for	to be
by: Ba doo fac saf	: ased on observation cument review, it wa illity staff failed to sto ely in two of three m	is not met as evidenced staff interview and facility is determined that the ore controlled substances dedication rooms, the one 100 and 200 hallways.					

hallway medication room.

The facility staff failed to store Lorazepam (1) and Marinol (2) behind double locks in the 100

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 FORM APPROVEL STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938-039 ANO PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETEO 495362 B. WING NAME OF PROVIOER OR SUPPLIER C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULO BE PREFIX CROSS-REFERENCEO TO THE APPROPRIATE (X5)TAG COMPLÉTION DATE OEFICIENCY) F 431 Continued From page 103 F 431 The facility staff failed to store Lorazepam behind double locks in the 200 hallway medication room. The findings include: On 10/6/16 at 11:55 a.m., observation was made of the medication room on the 100 hallway. LPN (licensed practical nurse) #1, the unit manager, accompanied the surveyor on the observation. LPN #1 unlocked the medication room. When the surveyor asked LPN #1 to unlock the medication refrigerator, LPN #1 was able to open the refrigerator without unlocking it. She opened an unlocked drawer and showed the surveyor six 0.25 ml (milliliter) syringes of Lorazepam and 118 Marinol tablets (2.5 mgs [milligrams] each). When asked if the Marinol and Lorazepam are considered to be controlled substances, LPN #1 stated: "Yes they are." When asked how these medications are to be secured, LPN #1 stated: "They should be behind two locks. I'm not sure what happened here." On 10/6/16 at 12:05 p.m., observation was made of the medication room on the 200 hallway. LPN #3 accompanied the surveyor on the observation. LPN #3 unlocked the door to the medication room. When the surveyor asked to see the narcotics in the refrigerator, LPN #3 opened the unlocked refrigerator and showed the surveyor four bottles of Lorazepam Intensol. The bottles had the following amounts remaining: 25 mls, 18 mls, 30 mls and 30 mls. LPN #3 was asked if Lorazepam is considered a controlled substance. She stated: "Yes." When asked how controlled substances are to be secured, she stated: "They are supposed to be locked."

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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	ILT I A	PLE CONSTRUCTION  G	(X3) D	O. 0938 ATE SURVI
<del>====</del>		495362	B. WING	<b>.</b>			C
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ASHLAN	NURSING AND RE	HABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET		
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	Эл 10/6/16 at 1:40 i	nm 49M#1 #5	F 4	31			
	auministrator, and g	SM #2 the discotor of					
î :	nursing, were inform	ned of these concerns.					
. A	A review of the facili	ty policy entitled "Storage and					
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_	THE MEDIUS LEVEN	lea in part the following					
. С	ontrolled substance	ire that Schedule II - V ss are only accessible to					
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μ	ersonner designater	d by facility: After and the					
Ų	oninoneo substance	S and adding to inventee.					
	ronney strouter ensure	s that Schedule II - V s are immediately placed					
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3.	ore ochiennie il Cou	ITOHAN SUbstance on July		i		,	
al	Ouse or diversion in	by facility to be at risk for a separate compartment					
441	rimi rije rocketi Wed	lication carie and chauta					
; ha	ive a different key o	r access device."				•	
No	further information	n was provided prior to exit.					
,		ed to relieve anxiety.					
, LO	i azepam is in a clas	SS Of medications are 1					
: 74	rizoulazepines. It wo	orks by slowing poticity to					
. 1116	i viairi lu allow fo <i>r te</i>	elayation "This interests		:			
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<hi>eds</hi>	tps://www.nlm.nih.g s/a682053.html>.	gov/medlineplus/druginfo/m		•			
C111C	i voniunta causea n	ol) is used to treat nausea y chemotherapy in people					
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cannabinoids. It work brain that controls in appetite." This informal website https://medlineplus.gtml.  "Dronabinol is a Schipotential for abuse leand 2. Has a current treatment in the Unit moderate or low physical dependentation of the website https://www.drugs.co	eficiency syndrome (AIDS). ass of medications called ks by affecting the area of the ausea, vomiting, and rmation is taken from the gov/druginfo/meds/a607054.h edule 3 medication Has a ass than those in schedules 1 by accepted medical use in ed States. Abuse may lead to sical dependence or high dence." This information is te m/pro/marinol.html.  CONTROL, PREVENT  blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.		DEFICIENCY	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	RE & MEDICAID SERVICES  (X1) PROVIOER/SUPPLIER/CLIA	<del></del>		PRINTED: 10/ FORM APP OMB NO. 093
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F 441 Continued From p	age 106			
determines that a r	esident non-de :	F 44	1	
Provoint tric apreau	Oliotection the facility			
			(2) Residents that reside in	) the
(2) The facility mus	t prohibit employees with a		racility have the potential to	he
			anected by poor infection	
TODITION OF CONTROL	WITH TASIMANTE OF that I		control practices. DCS has	
	ansmit the disease.  I require staff to wash their		conducted wheelchair	
rigines after Each Ul	FRCI regident contact		inspections and found none	to to
Masimir 12 100	UCATED by accepted		De ainty of in poor condition	
professional practic	e.		all Itials have been inspon	tad
(0) 1 5			by DCS and none have hos	· n
(c) Linens	41 .		found dirty. Bathrooms hav	e
transport linens so a infection.	dle, store, process and is to prevent the spread of		been inspected by DCS and soiled briefs were noted.	l no
; -			(3)Staff education will be	•
:			provided on infection	
This DECUIDENT	<del>.</del> .		handwashing to staff Week	1,
by:	T is not met as evidenced		audits of the infection control	y I
	on, staff interview, facility		109 Will be done x3 months	,
. accoment textem, an	Ciplical record route.		Audits Will be conducted	:
: Mes defettillest ivat	IDA tacility atok for 1	•	weeklyx3month of wheelche:	rs :
menitali all Ellective	Intection control names.		Audits will be conducted	
· O T I GCG DY I I GO I I G	IBIB Monthly infantion 1		weeklyx3months of fall mate	
E I AIII AGIIDGIA SOLO IU	FOLICIO ALICIUSE DO 40 I		Audits Will be conducted twice	_
two of 32 residents in	fection control practices for		a week and then once a wool	l,
: U Vooiuenis #3 and #1.	4): and fallow :- ( )		x2 months of bathrooms in the	e
resident batti (John IV S	l Clean manner ( ·		тастиу.	ı
and object of this Cilou	Lifesident hathroom		(4) The Quality	
between rooms 132 a	nd 134).		Assurance/Performance	
1 The facility atass s	-11.1		Improvement (OAD)	
The facility staff faile infection control logs.	of to have complete		Improvement (QAPI) team will conduct periodic audits to	J
infection control logs.  January 2016 through incomplete	ਸਾਦ ।πτection logs from August 2016 were		identify any noncompliance.	

incomplete.

Completion Date: 11-7-16

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILOING\_ (X3) OATE SURVEY COMPLETED 495362 B. WING NAME OF PROVIOER OR SUPPLIER C 10/06/2016

ASHLAND NURSING AND REHABILITATION

STREET AOORESS, CITY, STATE, ZIP COOE

906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Ol PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)

(X5) COMPLETION DATE

### F 441 Continued From page 107

- 2. The facility staff failed to provide wheelchair armrests and cushions in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #3.
- 3. The facility staff failed to provide fall mats in good repair, allowing them to be cleaned to prevent transmission of infection for Resident : #14.
- 4. Facility staff failed to ensure the resident bathroom between rooms 132 and 134 was free from a soiled brief on the floor causing contamination.

The findings include:

1. The facility staff failed to maintain a complete infection control program.

The review of the monthly facility infection logs from January 2016 through August 2016 was conducted. The following was documented: January 2016: 45 infections were documented, only four of them had the "site" of the infection documented. There were only two results of cultures documented. The column for "isolation -Yes/No" was blank, none recorded. February 2016: 38 infections were documented. Only four had the "site" of the infection documented. There were only four results of cultures documented. The column for "isolation -Yes/No" was documented for four infections, the others were blank. March 2016: 41 infections were documented. Fourteen had the "site" of the infection documented. There were no culture results

F 441

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: UQ8111

Facility IO: VA0008

RE(Cortinuator) sheet Page 108 of 126

NOV 0 3 2016 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 FORM APPRI STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938-ANO PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: A. BUILOING (X3) DATE SURVI COMPLETED 495362 B. WING NAME OF PROVIOER OR SUPPLIER C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEOED BY FULL PREFIX ΙĐ PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCED TO THE APPROPRIATE TAG DAT OEFICIENCY) F 441, Continued From page 108 documented. Two residents were documented F 441 as having been placed on isolation. The other spaces were blank. April 2016: 29 infections were documented. Ten had the "site" of the infection documented. There was one documented organism. There were sixteen columns checked if a resident was placed on isolation or not on isolation, the others were blank. May 2016: 33 infections were documented. Seventeen had the "site" of the infection documented. There was one documented organism. There were 11 blanks as to if a resident was placed on isolation or not on isolation, the others were blank. June 2016: 16 infections were documented. One failed to document the "site" of the infection. There were four documented organisms. There was no documentation in the column for if a resident was placed on isolation or not on isolation, the others were blank. July 2016: 40 infections were documented. Eleven documented the "site" of the infection. Only three organisms were documented. There were 18 documented in the column for if a resident was placed on isolation or not on isolation, the others were blank, August 2016: 49 infections were documented. One had the documented "site" of the infection. There were no organisms documented. There were 15 documented in the column for if a resident was placed on isolation or not on isolation, the others were blank. An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 10/6/16 at 11:10 a.m. ASM #2 reviewed the tracking logs with this surveyor. When asked if the site of an infection should be documented on

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	CONSTRUCTION	OMB N	D: 10/18/2 M APPROV O. 0938-0
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MALE OF THE	495362	B. WING		- <del>-</del>		C
NAME OF PROVIDER OR SUPPL	ER	1 /////			4.	=
ASHLAND NURSING AND	REHABII ITATION		214	REET AOORESS, CITY, STATE, ZIP COOE		0/06/2016
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F 441 Continued From	Dage 100		:			
the tracking logs	ASM #2 stated, "Yes." When	F 44	1			
THE PROPERTY OF THE	[DB [796][Da ]	1				,
	P() 35/27 if the			<i>:</i>		•
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, O Z SIGIGII ,	HS Winer collection					
. completes these f	TROKING IOGO ACLARO					
THE STATE OF THE S	iously is no longer employed d the purpose of tracking					
infections in the bu	illding, ASM #2 stated, "It's to					
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inceded if we see a	rise in a certain type of				_	
infection."					,	
The facility policy.	let e				:	
documented "The	Infection Control Surveillance" infection Control Committee is					
					3	
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Sourchiance indicate	)ES REP Charan IIII. (				1	
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TP GOTTINGS, IV, INDISTRICT	s of infections. iii. Unusual omial infection rate exceeds					
the baseline v Infecti	ons, populations or policies	:				1
which are: a, high risk	b High volume					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 STATEMENT OF DEFICIENCIES FORM APPR (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURVI COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING С STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX in PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLE DEFICIENCY) F 441 Continued From page 110 F 441 The administrator was made aware of the above findings on 10/6/16 at 11:44 a.m. No further information was provided prior to exit. 2. The facility staff failed to provide wheelchair armrests and cushions in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #3. Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, he was coded as having no cognitive impairment for making daily decisions. The resident was coded as using a wheelchair for moving around his room and the unit during the look back period. On the following dates and times, Resident #3 was observed lying in bed; his motorized wheelchair was located at the foot of the bed: 10/4/16 at 4:10 p.m.; 10/5/16 at 8:30 a.m. and 10:00 a.m. Attempts to interview Resident #3 at these times were unsuccessful. Both the wheelchair armrests were covered with a lamb's wool material. The covering was matted and

soiled. The coverings were secured to the arms with duct tape. The tape was chipped and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18 S TATEMENT OF DEFICIENCIES FORM APPRO (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION OMB NO. 0938-(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILOING \_ (X3) OATE SURVE COMPLETEO 495362 B. WING NAME OF PROVIOER OR SUPPLIER C STREET ADORESS, CITY, STATE, ZIP COOE 10/06/201 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX 'n PROVIOER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCEO TO THE APPROPRIATE COMPLE DATE OEFICIENCY) F 441 | Continued From page 111 foam rubber with no covering. The foam rubber F 441 was soiled and worn. On 10/6/16 at 10:30 a.m., LPNs (licensed practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied the surveyor to look at Resident #3's wheelchair. When asked to describe the armrests, LPN #14 stated: "It needs new arms." LPN #14 stated: "It is nasty looking." All three staff members agreed that the back cushion should have a cover, both for appearances and for comfort for the resident. When asked if the armrests and back cushion could be cleaned, all three staff members said they could not. When asked why this was important, LPN #10 stated: "For infection control." LPN #10 stated that she would notify therapy services to replace the armrest covers and the back cushion immediately. On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy entitled "Equipment Repairs" revealed, in part, the following: "All equipment in need of repair is returned to the vendor or manufacturer. We do not repair equipment. It is replaced." No further information was provided prior to exit. (1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication

between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/11 STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION FORM APPR (X1) PROVIOER/SUPPLIER/CLIA OMB NO. 0938 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) OATE SURV A. BUILOING COMPLETEL 495362 NAME OF PROVIOER OR SUPPLIER B. WING C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/20-ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH OFFICIENCY MUST BE PRECEOEO BY FULL PRÉFIX 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE PREFIX TAG OEFICIENCY) F 441 Continued From page 112 attack against its own tissues. In the case of MS, F 441

attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus." This information is taken from the website http://www.ninds.nih.gov/disorders/multiple\_sclerosis/multiple\_sclerosis.htm.

(2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement.

3. The facility staff failed to provide fall mats in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #14.

Resident #14 was admitted to the facility on 10/26/12 and most recently readmitted on 1/23/13 with diagnoses including, but not limited to: history of a stroke; COPD (chronic obstructive pulmonary disease( (1), heart disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 7/27/16, he was coded as being moderately impaired for making daily decisions. He was coded as having had no falls during the look back period.

On the following dates and times, Resident #14 was observed lying in his bed. On all observations, fall mats were present on both sides of his bed: 10/4/16 at 4:30 p.m.; 10/5/16 at 7:35 a.m., 8:30 a.m., and 1:20 p.m. On all observations, the grey fall mats were dirty, chipped and contained spatters of white paint scattered all over the mats.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18/201 STATEMENT OF OEFICIENCIES FORM APPROVE (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETEO A. BUILOING 495362 B. WING NAME OF PROVIDER OR SUPPLIER C STREET AOORESS, CITY, STATE, ZIP COOE 10/06/2016 ASHLAND NURSING AND REHABILITATION 906 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG OEFICIENCY) DATE F 441 Continued From page 113 On 10/6/16 at 10:35 a.m., LPNs (licensed F 441 practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied the surveyor to look at Resident #3's wheelchair. When asked to describe the fall mats, LPN #10 stated: "They are so dirty." CNA #14 identified the white blotches as "old paint" and stated the mats should be changed. When asked why it would be important for the mats to be cleaned, LPN #10 stated: "For infection control." On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) "COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topic s/copd. 4. The facility staff failed to ensure the resident bathroom between rooms 132 and 134 was free from a soiled brief on the floor causing contamination. On 10/4/16 at 1:25 p.m., tour of the facility was conducted. At 1:30 p.m., the bathroom in-between rooms 132 and 134 were observed to have a soiled brief on the floor in the corner. On 10/4/16 at 2 p.m., the soiled brief was observed on the floor in the corner of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/11 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA FORM APPR AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: OMB NO. 0938 A. BUILDING \_ (X3) DATE SURV COMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING С STREET AOORESS, CITY, STATE, ZIP COOE ASHLAND NURSING AND REHABILITATION 10/06/20-906 THOMPSON STREET SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (X4) IO (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) IO PROVIDER'S PLAN OF CORRECTION TAG (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCEO TO THE APPROPRIATE TAG OEFICIENCY) F 441 | Continued From page 114 F 441 On 10/4/16 at 2:45 p.m., a housekeeping staff member (OSM (Other Staff Member) #15) was in front of room 132. He was observed to start mopping the floor until he noticed the soiled brief. He alerted a CNA who worked that section to pick up the soiled brief. At 2:55 p.m., the CNA who worked that section disposed of the soiled brief. On 10/4/16 at 2:55 p.m., an interview was conducted with OSM #15. When asked how often he rounded on resident rooms to clean, OSM #15 stated that he mops and cleans every room after breakfast and before lunch so that cleaning supplies are not on the floor when meal trays are being served. When asked who was responsible for ensuring dirty Items like briefs are picked up off the floor, OSM #15 stated that if he sees items like soiled briefs, he will tell the nursing staff. OSM #15 stated that he cannot pick up soiled briefs and put them in his trash because he has to travel to every resident room with his cart. When asked if he saw the soiled brief in the bathroom in-between rooms 132 and 134, OSM #15 stated that he did. OSM #15 stated that as soon as he saw the brief, he had told the CNA and she picked the brief up off the floor. OSM #15 stated soiled briefs should not be on the floor due to contamination. On 10/4/16 at approximately 3:15 p.m., an interview was conducted with CNA (certified nursing assistant) #23. When asked how often CNAs rounded on resident rooms, CNA #23 stated that she rounds every 1-2 hours. When asked what rounding included, CNA #23 stated that it included checking on the resident to see if they are soiled, to see if they are having any

STATEMENT	OF DEFICIENCIES OF CORRECTION	KE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPL	- 00/101 VGC 110M	MB NC	1 APPR ). 0938 TE SURV
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1/41/15		495362	B. WING				С
NAME OF P	ROVIDER OR SUPPLIEF	3	_1,	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10	/06/20
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			_		SHLAND, VA 23005		
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F 441	Continued From pa						
,	safe, and to make	sure rooms are clean. When	F 4	41			
1	asked if resident ba	athrooms are included during		2			
į l	the rounding proce	ss to ensure they are close —					
. (	UNA#23 Stated tha	at resident hathrooms word					,
7.]	included. When as	Ked if soiled briefs should be					
1 <del>1</del>	err on the floor of a	resident's bathroom, CNA		i			;
f	Toor. CNA #23 stat	ed briefs should not be on the ted that it was the nursing staff		:		,	
. †	hat was responsible	e for picking up soiled items					
ii	ike linen and briefs			i			
_	Do 10/5/16 -+ 10:05					:	
c	conducted with CN4	a.m., an interview was A#12, the CNA who was					
а	ssigned to rooms 1	132 and 134 on 10/4/16.					
V	Vhen asked how of	ten CNA's rounded on					
: T6	esident rooms, CN/	A#12 stated that she rounded		:		-	
е	very nour and a ha	lf. When asked what		1		1	
in	ounding included, C	NA #12 stated that it		:		:	
lo	oking to see if hed	esidents or toileting them, or chair alarms are in place,					
: m	naking sure call bell	s are in reach, and to see if					
; rc	oms are clean, W	hen asked if cleanliness of					
, ru	oms included the r	esident's bathroom CNA 440					
: 51	ateo inal residents	Dathrooms were included		:			
, दा	in were checked to	r trash, clutter and items on		:			
ان	cked up the dirty hr	sked if she was the CNA who		·			
110	PUNS 132 200 134. I	UNA #12 stated that sha		:		:	
Wa	as. when asked if	dirty briefs should be on the		į			
: 110	, CIVA#IZ SIBIEC	l, "No. because of		1			
CO : tire	ntamination." CNA	#12 could not recall the last		:		!	
the	ne and was in that t	pathroom but stated that		į		i	
thr	ow them on the flo	who take off their briefs and or.		ž i			
: On sta the	n 10/5/16 at 5:11 p.r aff member) #1, the	n., ASM (administrative administrator and ASM #2, Nursing) were made aware				ų.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/18, STATEMENT OF DEFICIENCIES FORM APPRO (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION <u>OMB NO. 0938-</u> (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING\_ (X3) OATE SURVE COMPLETED 495362 B. WING NAME OF PROVIDER OR SUPPLIER C STREET ADDRESS, CITY, STATE, ZIP CODE 10/06/201 ASHLAND NURSING AND REHABILITATION 905 THOMPSON STREET ASHLAND, VA 23005 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PRDVIDER'S PLAN OF CORRECTION ΙD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE [X5] COMPLE CROSS-REFERENCEO TO THE APPROPRIATE TAG DEFICIENCY) DATI F 441 Continued From page 116, F 441. No policy could be provided regarding the above No further information was presented prior to exit. F 465 483.70(h) SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABL F 465 **E ENVIRON** F465, 12VAC5-371-370 The facility must provide a safe, functional, (1) On Unit#1 wall across from sanitary, and comfortable environment for 125 was repaired, carpet on residents, staff and the public. wall across from 122 was repaired, ceiling tiles above nurses station replaced, cove This REQUIREMENT is not met as evidenced base at entrance of nurses by: station and 105 were replaced, Based on observation and staff interview, it was ice machine room and shower determined that the facility staff failed to maintain room were cleaned. On Unit #2 a functional, safe, sanitary, and comfortable environment on three of three units, (Unit #1, Unit the carpet between 213 and #2 and Unit#3). 215 was repaired, ceiling tiles near the nourishment room The facility staff failed to maintain common areas were replaced, the ice machine on all three of the facility units. and shower rooms were cleaned. On Unit #3 ceiling The findings include: tiles outside of room 327 were replaced. Handrails throughout Observations during the days of the survey on the facility were repaired. Unit # 1 revealed the following: The wall across from resident room 125 was observed to be caved in above the cove base (baseboard). The (2) All residents have the carpet on the wall across from resident room # potential to be affected by 122 was coming off the wall. There were brown deficient facility maintenance. stains on the ceiling tiles (three) around the nurses' station and the cove base at the one entrance to the nurses' station near resident room #105 had a damaged corner and cove base missing. The unit ice machine located across the

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES				PRINTED: 10/18/2011 FORM APPROVEL
ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILO		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETEO
NAME OF PROVIOER OR SUPPLIER	495362	B. WING		С
ASHLAND NURSING AND REHABILITATION			STREET AOORESS, CITY, STATE, ZIP COOE 906 THOMPSON STREET	10/06/2016
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F 465 : Continued From page	447			

## F 465: Continued From page 117

hall from resident room # 120 was observed to have gloves and what appeared to be white paper towels on the floor in the back right hand corner. The unit shower room was observed to have an unflushed toilet, two adhesive bandages on the floors of two showers and a piece of gauze and tape on the floor of one shower.

Observations during the days of the survey on Unit #2 revealed the following: The carpet on the wall between resident rooms # 213 and 215 was coming off the wall. There were brown stains on the ceiling tiles outside the nourishment room and around the air return vent on the ceiling. The air return vent was dusty. The unit ice machine located across the hall from resident room # 228 was observed to have gloves on the floor in the back left hand corner. The unit shower room was observed to have one shower drain clogged with hair and near a shower bed there was a blue disposable razor on the floor.

Observations during the days of the survey on Unit #3 revealed the following brown stained ceiling tile outside resident room # 327.

Observation during the days of the survey revealed that handrails on all three units on both the right and left side of the halls were found to be in poor condition. This was characterized by chipped and peeling paint and small gouges revealing a semi-rough surface.

On 10/6/16 at beginning at approximately 9:00 a.m. an observation of all three units was made with OSM (other staff member) # 1, the director of maintenance, OSM #5, the director of housekeeping, and OSM #6, the area manager. OSM # 1 stated that staff do rounds every

F 465

- (3) The facility will (a) review its policies & procedures ensuring maintenance and cleanliness of the facility. (b) In-service maintenance department and other management staff on policy (c) Staff making rounds will complete Maintenance work orders as needed Maintenance will complete items from the Maintenance log and turn into the Executive Director or designee to sign and monitor weekly for three months. Maintenance and Housekeeping staff will monitor facility audit of designated areas weekly for three months
- (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

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STATEMENT (	S FOR MEDICAL  OF DEFICIENCIES  CORRECTION	TH AND HUMAN SERVICES RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPLE	E CONSTRUCTION	,	VTED: ORM A BNO. 0	PPROV
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F 465	ontinued From p	ane 118	14 8 1	ī	DEL IOIENCE)	<u> </u>		
n	orning and then.	renort any issues at the	F 46	35				
- 11	ivitility meeting.	( ) SM # 1 ctatad + L = L L	:					
<u>_</u>	were marriere w	3S 3D ISSUE With the					1	
0.		illing tiles are a result. OSM # 1 lify was working on getting the	:				<b>4</b>	
	or repaired. At it	IIS IIMe a request upa	:				,	
10	i eily uocumentai	UOD Of the roof iccur. Dole 11.					f	
446	as also at fulls film	e asked for any work	:					
the	ony of the items	identified on this tour. When ice machine floor on Unit # 2		i				
44.5	えっ しつうらい くらい こういい	[ # 5 removed the at		:				
V V	rine trie opservati	On Was ongoing in the at-	;					
	2011 VII VIII # 1. (	おがい 幸力 ひにとりゅう わっしょうしょ						
the	facility policy on	and OSM # 5 were asked for maintenance repairs and						
, 101	195veehiiin 86tAK	CAS A reguest was at-						
11116	ine ini alik doctil	Tentation that either occurred						
OI 1	OSM # 5 wanted	to present.						
Du	ring an interview o	on 10/616 at 10:35 a.m. OSM					÷	
17 U	Thi esertion (SCIIII)	/ DOLICIES for Alabaria - III			•		•	
3110	MACH IOONING SUID &	iated that housely contain a second		·				
,	ALIGNIC TO DEFINIT	to the shower rooms because ongoing the day before.		j				
	At to 0 0116160 110 8	EXPLANATION for the glaves						
, GHU	wash near the lo	e machines Atthictions						
allo	uter policy was re	Ottested for cleaning the						
( 1100)	is aloung the Ice	machines. This policy						
		5 on 10/6/16 at 11:45 a.m.						
Duri :	ng an interview or	n 10/5/16 at 11:25 a.m. with						
14	(licensed practic d how maintenar	alnurse)#2 lon#2					•	
com	municated to the	maintenance staff 1 DN 4/0						
SIGIO	in mar ii filete ate	BOV ISSUES With Home +L-+						
11000	i to ne rebalted of	DB CAD Bist grob one as a						
1110111	renance crew Mu	eп one sees tham in the						
main	ey. Erix#2 furti tenance deportm	ner stated that the ent is very responsive to						
	The doparting	encia very responsive to						

T1T51:5:5:5	RE & MEDICAID SERVICES			7.6	ITED: 10/18/2 ORM APPROV
TATEMENT OF OFFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	LTIPLE CONSTRUCTION DING	OIVIB	NO. 0938-03 OATE SURVEY COMPLETEO
	495362	B. WING	<b>:</b>		C
NAME OF PROVIDER OR SUPPLIE	R	1			10/06/2016
ASHLAND NURSING AND R			STREET AOORESS, CITY, S 906 THOMPSON STREET ASHLAND, VA 23005	TATE, ZIP CODE	
PRICHA LEAGH DEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	ID PREFI TAG	PROVIOER'S PL IX (EACH CORRECT CROSS-REFERENC	AN OF CORRECTION IVE ACTION SHOULO BE EO TO THE APPROPRIATE FICIENCY)	(X5) COMPLETH E DATE
F 465 Continued From prequests and to ge	age 119 etting repairs completed.	F 4			<u> </u>
was asked how more communicated to a stated that one can they come and tak further stated that communication be maintenance come you they can just less tated the maintenance come LPN # 1, LPN # 1 vissues are communication be staff. LPN # 1 states also one can call the but one should always book too. LPN # 1	w on 10/5/16 at 2:30 p.m. with se's assistant) # 2, CNA # 2 aintenance issues are the maintenance staff. CNA # 2 in just page maintenance and e care of the issues; CNA # 2 one can write the issue in the ok - that way when es to the unit if they cannot find ook in the book. CNA # 2 ance staff is excellent.  I on 10/6/16 at 8:25 a.m. with was asked how maintenance and that there is a log book and e maintenance department ays put the request in the log stated that maintenance is ting any requests completed.				
was asked what is dependenced bandages on the flow # 12 stated that one bandages and then come and disinfect to the During an interview of ASM (administrative administrator, was mobservations and a remade at this time. A	on 10/6/16 at 10:10 a.m. staff member) #1, the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/1 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA FORMAPPE AND PLAN OF CORRECTION OMB NO. 0938 IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING \_ (X3) DATE SURI COMPLETE 495362 NAME OF PROVIDER OR SUPPLIER 8. WING C STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 10/06/20 906 THOMPSON STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ASHLAND, VA 23005 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ΙD TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 465 Continued From page 120 presented by ASM # 4, Regional director, on F 465 10/6/16 at 1:10 p.m. documented the following: under "Policy" "The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair." Under "Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form (Attachment A). The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and further resolution." Review of the facility policy "DUST MOPPING" presented by OSM # 5 on 10/6/16 at 11:45 a.m. documented the following: under "WASHROOM: always use dust mop before bringing water into room. Pick up trash & debris at door. HALLWAYS AND COMMON AREAS: Use larger dust mop when working in halls. Run mop along baseboard then mop back using a "figure 8" motion. Pick up trash." An additional policy: "Job: Step 4, Sanitize Sink and Tub" under "Step # 3 Clean and Sanitize

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES	& MEDICAID SERVICES			PRINTED:
ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION	OMB NO. (
NAME OF PROVIDER OR SUPPLIER	495382	B. WING		(X3) OATE : COMPL
ASHLAND NURSING AND REH.	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE	C 10/05
(X4) IO SUMMARY STATE	MENT OF OFFICIENCIES		906 THOMPSON STREET ASHLAND, VA 23005	
REGULATORY OR LSC	IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDERS PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE	TION JLO BE CO
F 465 Continued From page Shower Stall 1. Spray fixtures and wipe, use		F 466		OPRIATE
Another police at a second	progras needed.	; ;		•
not limited to peti-	e followed, including but		· · · · · · · · · · · · · · · · · · ·	·
rooms, offices, diet kitch and sitting rooms" Un Hospitality Seniors 2	nens, storage spaces, TV	, , ,		
cleanliness of all interior aboveBe familiar with cross confamination	areas Indicated egulations relating to		F 514 (1)The urinalysis laboratory	
compliance"	and monitor	toppe	resident #17's - b	
No further information wa the survey. F 514 483.75(I)(1) RES SS=D RECORDS-COMPLETE/A		F 514	correctly filed. The laborato file misfiled in resident #6's chart was correctly filed. The laboratory results and the	ry :
The facility must main			the appropriet	in -d
resident in accordance with standards and practices the accurately documented; reasystematically organized.	OCCUPATION DINESCIANT	an In the section of	potential to be affected by the practice. The facility will conduct an audit	is
The clinical record must con	ntein sufficient sident; a record of the		identify any charts/clinical	to :
resident's assessments; the services provided; the results preadmission screening condand progress notes.	Light of Cale Suy	· :	information.  (2) All residents have the potential to be affected by this	; ;
This REQUIREMENT is not n	net as evidenced	:	- arrected by this	:
IS-2567(O2-99) Previous Versions Obsolete	Event IO: UQB111	Facility Io	RECEIVED	

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AME OF PRO	OVIOER OR SUPPLIER		D. V/114G	STREET AODRESS, CITY, STATE, ZIP COOE	10/0	<u>6/</u> 2016
SHLAND	NURSING AND REP	IABILITATION		906 THOMPSON STREET		
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by B arth ac Re 1. reich 2. (ia Th 1. 2/1 that diff Alz Reich cod staf dep hygi Rev two	ased on staff intend facility document at facility staff failed curate clinical reconsidents #17 and 6. The facility staff filled sult for two different art.  For Resident #6, a b) results were filed findings include:  Resident #17 was 3/13 and readmitted to included but were inclu	view, clinical record review t review, it was determined d to maintain a complete and		practice. The facility conduct an audit of 1 the resident medical identify any charts/cli records with misfiled information.  (3) The facility will repolicies and procedure ensuring knowledge of filing of resident inform with nursing staff and records department. A be conducted weekly months for 5 residents to ensure compliance.  (4) The Quality Assurance/Performance Improvement (QAPI) te conduct periodic audits identify any noncompliance.  Completion Date: 11-7.	20% of records to nical resident riew res f proper reation medical udits will a charts ream will to nce.	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/ CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPRO STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-(X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVE A. BUILDING\_ COMPLETED 495362 B. WING C NAME OF PROVIDER OR SUPPLIER 10/06/201 STREET ADDRESS, CITY, STATE, ZIP CODE

ASHLAND NURSING AND REHABILITATION

905 THOMPSON STREET ASHLAND, VA 23005

PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**PREFIX** TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

DATE

F 514 Continued From page 123

F 514

On 10/6/16 at 9:10 a.m., an interview was conducted with RN (Registered Nurse) # 1, the unit manager. RN #1 stated that once nursing receives a laboratory result, the result is faxed to the physician and placed in the clinical record by nursing.

On 10/6/16 at 2:13 p.m., an interview was conducted with ASM (administrative staff member) #4, The Regional Director of Nursing Services. When asked who was responsible for filing laboratory tests, she stated that either the nursing staff or medical records filed labs. She stated that the two labs in Resident #17's chart that belonged to the two different residents should not have been in the clinical record.

On 10/6/16 at 2:30 p.m., ASM #2, the DON (Director of Nursing) was made aware of the above concerns. She stated that when labs come into the facility, it is faxed to the physician either by the nurses or medical records and then placed in the clinical record.

The facility policy titled, "Clinical/Medical Records," documented in part, the following: "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The clinical record shall contain - information to identify the resident clearly, a record of the resident's assessments; the plan of care and services; the results of pre-admission screening...In addition, the resident's clinical record shall be readily accessible and systemically organized to facilitate retrieving and compiling information."

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	OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES  (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	CONSTRUCTION	OWB M	М АРР <u>О. 093</u>
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NAME OF PE	ROVIOER OR SUPPLIER	495362	B. WING				С
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F 514 C	Continued From pa Io further informati	ge 124 on was presented prior to exit.	F 51	4	DEFICIENCY)		
in in In	(1) Urinalysis-A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. This information was obtained from The National Inslitutes of Health. https://medlineplus.gov/urinalysis.html.						
		:					
. 2. . we	For Resident #6, a re filed on the clini	another resident's lab results cal record.					
to: dise	dementia, chronic ease, rib fracture	itted to the facility on es including but not limited obstructive pulmonary lysphagia, high blood sm, and psychosis.		: : :			
The qual Refe code abilit was	most recent MDS rterly assessment erence Date) of 6/3 ed as being severe ty to make daily life	(Minimum Data Set) was a with an ARD (Assessment 30/16. The resident was ely cognitively impaired in the decisions. The resident				:	

on it.

dressing, and transfers; and was coded as

A review of the clinical record for Resident #6 revealed a lab result of a urinalysis (1) obtained on 9/19/16, which had another resident's name

incontinent of bowel and bladder.

	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  [X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE	CONSTRUCTION	(X3) DA	/ ADDoc
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ASHLAN	PROVIDER OR SUPPLIER  ND NURSING AND REP	Eler		ST/ 906	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		C /06/201
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1 4 2		.m., in an interview with LPN al Nurse), she stated that the	F 51	4	DEFICIENCY)		DATI
		m., the Administrator (ASM aff member #1) was made No further information was f the survey.				;	
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St. Colon St. Colon Colo					VDH(OLC		

State of Virginia PRINTED: 10/18/2016 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING CDMPLETED 495362 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE ASHLAND NURSING AND REHABILITATION 10/06/2016 906 THOMPSON STREET ASHLAND, VA 23005 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (X5) COMPLETE TAG F 000 Initial Comments DEFICIENCY DATE F 000 An unannounced biennial State Licensure Inspection was conducted 10/4/16 through 10/6/16. Corrections are required for compliance F001 with the Virginia Rules and Regulations for the (1) A criminal background Licensure of Nursing Facilities. The Life Safety check has been obtained on Code survey/report will follow. the employee whose file was cited The census in this 190 certified bed facility was (2) The facility will conduct a 162 at the time of the survey. The survey sample 100% audit of all employee consisted of 26 current resident reviews files to identify any employees (Residents #1 through #22 and #29 through #32) and six closed record reviews (Residents #23 without the required criminal background check. through #28). (3) Facility will (a) review its F 001 Non Compliance policies and procedures F 001 The facility was out of compliance with the ensuring that all employees following state licensure requirements: have a criminal background check completed within thirty This RULE: is not met as evidenced by: days of hire. (b) The NHA and The facility was not in compliance with the the HR Director will sign/initial following Virginia Rules and Regulations for the the criminal background check Licensure of Nursing Facilities: of each employee within three business days of its receipt, as 12VAC5-371-250 Resident Assessment and care well as a pre-hire checklist planning - F278 completed with said signatures 12VAC5-3731-250 Policies and procedures completed (4) The Quality F226 Assurance/Performance Improvement (QAPI) team will 12VAC5-371-140 Policies and procedures - see conduct periodic audits to citation below: identify any noncompliance. Completion Date: 11-7-16 Based on staff interview and facility document review, it was determined that the facility staff failed to ensure a licensure verification was RECEIVED LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE NOV 03 2016 TITLE VDH/JI

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through #28).	Tenews (Residents #	23			yees	
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This RULE: is not me The facility was not in following Virginia Rute	t as evidenced by:	ĺ	İ	TO STOLL THE CV COLUMN ACCES	-	
following Virginia Rule	compliance with the			audit of employee files for		
Licensure of Nursing F	acilities.	he		license verification and		
<b>!</b>		į į	Ì	reference checks. NHA will		
12VAC5-371-250 Resignation	dent Ass≘ssment and a	Cere i	Ì	audit all new hires monthly months.	ХЗ	
planning - F278	aria (			(4) The Quality		į
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	•	ļ	ļi	identify any noncompliance.	!	]
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citation below:	,	) G		Completion Date: 11-7-16		
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failed to ensure a licensu	u mar the facility staff		j	NOV 0 3 2016	Ì	
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	o viigina, for one d	ince with the laws of of 25 employee recor erence check comple records reviewed.	·d-0				
	The findings include	ed:					
	Review of the state of documents "E. Person shall include, but are and complete person including: a. Venifica license, registration, a required approved  On 10/6/16 a review new hires for the last This review revealed  1) OSM (other staff of the replication) the staff of the replication of the staff of the replication of the staff of the sta	onnel policies and prenot limited to: 3. Are not limited to: 3. Are not record for each ation of current professor certificate or comparing course;"  of 25 employee record two years was conducted to the following:  member) #2, physical professor 2/29/16, the facility are verification at the pocumentation was professor and the pocumentation was professor to the following and the pocumentation was professor to the facility are professor to the pocumentation was professor to the facility and the pocumentation was professor to the facility and the pocumentation was professor to the facility and the pocumentation was professor to the facility and the pocumentation was professor to the facility and the pocumentation was professor to the facility and the pocumentation was professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the professor to the facility and the facility and the professor to the facility and the professor to the facility and	ocedures accurate employee ssional pletion of ords of ucted.				
22	person.  2) CNA (certified nursion 10/12/15, the facilities at the	ing assistant) #21 ways staff failed to obtain	as hired				
fi	Documentation was no iles that indicated that nad been requested fro	ot included in their ei ta personal referenc	mnlovas			EIVED	
h in	) CNA#22 was hired alled to obtain referen ire at this facility. Doc acluded in their emplo personal reference cl	ce checks at the tim umentation was not yee files that indicate	e of		NOV : <b>V</b> DH	0 3 2016 VOLC	

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	from any person.						
the state of the s	On 10/6/16 at appro- (administrative staff Administrator and Of- resources director) we documentation in the records. ASM #1 and should be in each en- the time of hire. OSM checks, license verific check and a drug scritcheck and a drug scritcheck and a drug scritche purpose of obtain #18 stated, "To protect the abuse policy, it is further stated that he documents were not in required; he had not be for very long but was a process for employee	member) #1, the SM #18 (the human vere aware of the mile above referenced at 10 SM #18 were as imployee record prior M #18 stated, "Refer cation, a state backgeen." OSM #18 waing these document of the residents. It is prevention." OSM # could not speak to you the employee record working at the emproying at the emproying on improving an improving an improving state of the second of the emproying an improving an improving an improving second working an improving second	issing employee ked what to or at rence ground as asked as. OSM s part of #18 why these preds as				
\	A review of the facility revealed, in part, the for Screening: Persons a with a The (sic) Compart for a history of abuse, it residents to include: Recurrent employers (with Criminal Background cappropriate licensing brine. Swom Disclosure /erify license or registra	Dilowing documenta applying for employr any facility will be so neglect, or mistreati eferences from prevan applicant permissi heck. Abuse check oard and registries, statement prior to	tion: ment reened ng rious or on).		RECEIVE NOV 9 3 20 VOHIO	ED	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/24/2016 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/O			E CONSTRUCTION Ot - MAIN BUILOING Ot	(X3) OATE SURVEY COMPLETEO	
		495362		B, WING		10/20/2016	
j	OVIOER OR SUPPLIER		STREET AOORE:				
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K 000	INITIAL COMMENTS			K 000			
	with NFPA-13  An unannounced Rec survey was conducted with 42 Code of Fede Requirements for Lonfacility was surveyed LSC 2000 Existing res	ype II(000) y sprinklered in accordance tification Life Safety d 10/20/16 in accordance Regulation, Part 48 ag Term Care Facilities for compliance using the gulations. The facility in the Requirements for	Code ice 3: . The ne		Ashland Nursing and Rehabilitation ("Facility") filing this plan of correction purposes of regulatory compliance. The Facility submitting this plan of correction to comply with applicable law. The submission of the plan of correction does not represan admission or statement agreement with respect to alleged deficiencies.	n for is the sent it of	
K 025 SS=E	The findings that follo non-compliance with Regulations, 483.70(a) et seq (Life NFPA 101 LIFE SAFE	Title 42 Code of Safety from Fire.)	D	K 025			
J33-E	least a one half hour toonstructed in accord barriers shall be permatrium wall. Windows fire-rated glazing or by steel frames.  8.3, 19.3.7.3, 19.3.7.5. This Standard is not	ance with 8.3. Smoke alted to terminate at an shall be protected by y wired glass panels and the state of the state of the state of the smoke and could ne side of the smoke	nd nd ke		KO25 Step 1All penetrations, joint, openings have been sea thus preventing the pass smoke from one side of smoke barrier to the other.	led sage of the	
LABORAFORY	DIRECTOR'S OR PROVIOER	SUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE	r	(XS) OATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days tollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable to days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## Step 2.

-All residents within the facility have the potential to be affected by deficient/inadequate facility maintenance practices.

## Step 3.

-The relative regulation will be reviewed by the Administrator, Maintenance Department employees, and Environmental Services Department employees.

-The facility's Policies and Procedures related to proper maintenance of smoke barriers will be reviewed.

-Policies/Procedures will be generated/revised if required.

-Appropriate staff
(Administrator, Maintenance
Dept, Environmental Services
Dept.) will be educated
regarding said
Regulations/Policies/Procedur
es/Revisions and the
importance of compliance.

### Step 4.

-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Audits to identify ineffective smoke barriers will be

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES Printed: 10/24/2016 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/O		( '	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) OATE SURVEY COMPLETED			
		495362		B. WING		10/20/2016			
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K 025	Continued From pag	e 1		K 025					
	Findings include:				conducted monthly X 3				
	Between 3:00 PM and 7:20 PM on 10/20/16 it is		it is	į	months to verify complian	ice.			
	observed that there are penetrations above the cellings in the fire rated smoke barrier walls that have not been fire stopped with a listed design and product in Wing 2 Back Hall above the cross corridor doors near room 220, and by Wing 3			# ### P	-Results will be reported a the monthly QAPI Meetin appropriate.	at g as			
	Front Hall above the room 314.	cross corridor doors ne	ar		Step 5,				
K 048 SS=E	NFPA 101 LIFE SAFE	ETY CODE STANDARI	o	K 048	-Date of completion: 11-8	-16			
	patients and for their an emergency. 19. This Standard is not K48 Based upon observat documentation that the plan does not contain information in the plan Findings include:  Between 3:00 PM and during review of the extensive documentation for the plan was out of date, that shows the locatic compartments, the locating compartments, the locating and alternate rewritten plan does not	ne emergency evacuation all of the required in  d 7:20 PM on 10/20/1 emergency evacuation we the complete aftre evacuation plan. It did not contain a dia on of the smoke cation of the fire attons, locations for defoutes of evacuation. The	on  6 plan The gram end in		K048  Step 1.  -An updated emergency evacuation plan has been developed including comdocumentation and diagraphic which address all aspects necessary for an adequate plan.  Step 2.  -All residents within the facility have the potential be affected by deficient/inadequate evacuation plan.	plete ams e			
К 060 SS=F		ETY CODE STANDAR	D	K 060					
30-r	Initiation of the requir	ed fire alarm systems	shall						

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## Step 3.

- -The relative regulation will be reviewed by the Administrator, Maintenance Department employees.
- -The facility's Policies and Procedures related to evacuation will be reviewed.
- -Policies/Procedures will be generated/revised if required.
- -Appropriate staff will be educated regarding said Regulations/Policies/Procedur es/Revisions, their specific role(s) in the evacuation process, and the importance of compliance.

## Step 4.

- -Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.
- -Audits to identify evacuation plan deficiencies will be conducted monthly X 3 months to verify compliance.
- -Results will be reported at the monthly QAPI Meeting as appropriate.

## <u>Step 5</u>.

-Date of completion: 11-8-16

#### K060

### Step 1.

-The sprinkler system has been repaired by Simplex Grinell such that when the system experiences a water flow condition, a signal to alarm the building fire alarm system and not as a supervisory alarm.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/24/2016 FORM APPROVED OMB NO. 0938-0391

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			10/			20/2016		
NAME OF PROVICE	DER OR SUPPLIER		STREET AOOR	ESS, CITY, STAT	TE, ZIP COOE		······································	
ASHLAND N	URSING AND REH	ABILITATION		OMPSON ST ND, VA 2300	· · · · ·			
(X4) IO PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDEO BY FULL RE ENTIFYING INFORMATION)		IO PREFIX TAG	PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE	IX5I COMPLETIO OATE	
K 060 C	ontinued From page	∋ 2		K 060			<del>-</del>	
be de 18 Th K6 Ba ob spi not sys	by manual fire alar tection, or extinguise. 3.4.2, 19.3.4.2, 9.6 is Standard is not seed upon review of servations that whe rinkler system that it send a signal to a stem.  Indings include:  It ween 3:00 PM and ring review of documents of the sprinkle itch for the sprinkle adition that it reports	m initiation, automatic shing system operation	pes arm 6 ller bw v	K VOU	Step 2.  -All residents within facility have the posterior by a deficient/inadequate control system.  Step 3.  -The relative regulate be reviewed by the Administrator and a members of the Administrative team.  -The facility's Policier.	tential to e fire tion will ill i.		
K 072 SS=E  Me ma imp or o the sha Thi Bas equ req and Fine	eans of egress shall intained free of all opediments to full insother emergency. Nother objects shall oreto, egress there fall be in accordance is Standard is not resed upon observatiouired elements are discontinuity.  I dings include:	obstructions or stant use in the case of to furnishings, decoration of the case of the function of the case of the	f fire ions, of 9.2.1 at are por	K 072	Procedures related to safety will be review relative to the application.  -Staff will be educate regarding said Regulations/Policie es/Revisions and the importance of comprelative to resident.	ved table ted s/Procedur e pliance		

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## Step 4.

- -Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.
- -Periodic audits to identify inoperative sprinkler water flow switches will be conducted Monthly X 3 months to verify appropriate function.
- -Results will be reported at the monthly QAPI Meeting as appropriate.

## Step 5.

-Date of completion: 11-8-16

### K072

### Step 1.

-The egress door from the southern end of the corridor has been posted with directions for operating/unlocking it. The egress door from the Maintenance Office has been repaired. It no longer hits the frame and does not require excessive force to open.

#### Step 2.

-All residents/staff within the facility have the potential to be affected by a deficient/inadequate system of egress.

#### Step 3.

-The relative regulation will be reviewed by the Administrator and all members of the Administrative team.

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- -The facility's Policies and Procedures related to fire safety and adequate egress will be reviewed relative to the applicable regulation.
- -Policies/Procedures will be generated/revised if required.
- -Staff will be educated regarding said Regulations/Policies/Procedur es/Revisions and the importance of compliance relative to resident/staff safety.

## <u>Step 4</u>.

- -Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.
- -Periodic audits to identify violations of egress policy will be conducted monthly X 3 months to verify appropriate function.
- -Results will be reported at the monthly QAPI Meeting as appropriate.

## <u>Step 5.</u>

-Date of completion: 11-8-16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/24/2016 FORM APPROVED OMB NO. 0938-0391

			) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LE CONSTRUCTION : 01 - MAIN BUILOING 01	(X3) OATE SURVEY		
AIOCAIT	SI CONNECTION	IDENTIFICATION NOMBE	:K;	A, BUILDING	OT - WAIN BUILDING OT	COMPLETEO		
		495362	,	B. WING		10/20	0/2016	
į.	ROVIOER OR SUPPLIER	A DAL INTERNATION		RESS, CITY, STA				
ASHLAN	D NURSING AND REH	ABILITATION		OMPSON ST ND, VA 230				
(X4) IO PREFIX TAG	ÉFIX (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY			IO PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)		
K 072	, –			K 072				
		gnetic lock and the sign to operate and unlock on the door.						
K 130 SS=0	office is hitting the fra force to open the doo NFPA 101 MISCELLA OTHER LSC DEFICII This Standard is not K130	loor to the maintenance me and requires exces r in the direction of egra NEOUS ENCY NOT ON 2786 met as evidenced by:	e sive ess.	K 130	-Periodic audits to confit the presence of updated MSDS Manuals in the appropriate locations with conducted monthly X 3 months to verify compli	ll be		
	were not up to date. Findings include:		6 it is		-Results will be reported the monthly QAPI Meet appropriate.			
	in wing 1, and service	hall area. Referenced on Code Section 5003.	by 4		Step 5Date of completion: 11	-8-16		
SS=D	1	equipment shall be in onal Electrical Code. 9-9.1 met as evidenced by: ions the electrical system being maintained.  17:20 PM on 10/20/16 akers in the electrical pain in Wing 1 is not labeling maintained.	ems it is eanel ed as	K 147	K147  Step 1.  -The breaker in question been labeled appropriate Other breakers have been inspected to ensure probabeling.	tely. een		

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## <u>Step 2</u>.

- All residents/staff within the facility have the potential to be affected by the absence or improper labeling of electrical circuits.

## Step 3.

- -The relative regulation/code will be reviewed by the Administrator and the Maintenance Dept.
- -The facility's Policies and Procedures related to the maintenance and management of electrical system maintenance will be reviewed relative to the applicable regulation/code.
- -Policies/Procedures will be generated/revised if required.
- -Appropriate staff (the Maintenance Dept.) will be

educated regarding said Regulations/Codes/Policies/Pr ocedures/Revisions and the importance of compliance.

## Step 4.

- -Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.
- -Periodic audits to confirm proper labeling of electrical panel circuit breakers will be conducted monthly X 3 months to verify appropriateness.
- -Results will be reported at the monthly QAPI Meeting as appropriate.

#### <u>Step 5</u>.

-Date of completion: 11-8-16